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LONG TERM CARE SURVEY

DEPARTMENT OF HEALTH & HUMAN SERVICES USA

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THE LONG TERM CARE SURVEY PROCESS

TRAINING MANUAL

HEALTH CARE FINANCING ADMINISTRATION
HEALTH STANDARDS AND QUALITY BUREAU

HE 22.206:

AGENDA

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PARTICIPANT LIST

FACULTY LIST

OBJECTIVES

OBJECTIVES

At the end of this training program, participants will be able to:

- describe the philosophical intent and development of the new survey instrument.
- conduct and document a survey using the new instrument.
- conduct an interview sensitive to resident needs and observe and gather data to support the surveyors' compliance decision.

BACKGROUND

PaCS: The Early Stages

Introduction

The current survey system, which has been in effect since 1974, was aimed at addressing the many shortcomings in nursing home care that became evident in the late 1960s and early 1970s. The process focuses on structural requirements (such as written policies and procedures, staff qualifications and functions, the presence of specific agreements and contracts, and a physical plant with particular characteristics) more than on patient outcomes, on the assumption that, if the structural requirements are met, the desired outcome-that is, high quality care-will be attained.

Beginning in 1978, the Department approved a number of demonstration projects and experiments with modified survey processes that would focus more directly on actual care provided rather than structural requirements. Each demonstration or experiment sought to develop methods and indicators that would reveal the quality of care provided rather than the facility's capacity to deliver care. In 1982 HCFA began to devise a new survey procedure based on the results of the demonstrations and experiments. This is referred to as the Long Term Care (formerly Patient Care and Services (PaCS)) survey.

On May 27, 1982, HCFA proposed changes in the survey and certification procedures [47 FR 23404] which elicited significant public response. This caused HCFA to reexamine the survey process.

As part of this reexamination, HCFA called a series of meetings with representatives of consumer advocacy groups, State agencies and the nursing home industry, to identify what might be acceptable changes in the survey and certification process. The work group agreed that the survey process would be substantially improved if it focused on care provided, and identified observation and assessment of patients or residents as the proper primary basis for compliance decisions. The participants unanimously supported the implementation of an outcome-oriented survey process on a national a basis.

Also, in 1982, HCFA staff evaluated numerous survey approaches and instruments in an effort to identify and categorize specific performance indicators directed at the care actually provided by the facilities. They also reviewed the various models governing the use of these indicators. The review encompassed a wide range of programs including formal State demonstrations and experiments, integrated IoC/survey procedures, PSRO long term care review systems, industry quality assurance tools, and past Federal approaches such as the Patient Care Management System and the Patient Appraisal and Care Evaluation instruments. Drawing on each of these sources, HCFA staff completed development of the original version of the PaCS survey instrument in September 1983.

Although the subsequent testing and refinement process have resulted in numerous revisions to the PaCS form and procedures, the new long term survey process maintains the essential features of PaCS. The new approach continues to emphasize review of the provision of resident care and services through an integrated system of resident observation, interviews and record reviews.

The First PaCS Trial

The original PaCS instrument was used for the first time on October 15-18, 1983. Central office surveyors conducted a pretest of the tool in three Maryland nursing homes to see if it was a viable review mechanism. The surveyors recommended several changes in the length and formatting of the survey form but agreed that further testing was merited. After instituting the recommended revisions, HCFA unveiled the PaCS instrument to the groups involved in the Subpart S meetings in November 1983, and with their support, prepared for its first formal field testing.

Pilot Test 1

Following two days of surveyor training in December 1983, PaCS was field tested in three regions between 12/16/83 and 1/20/84. The test involved the performance of parallel PaCS and traditional surveys in four facilities in each region, encompassing a cross-section of compliance histories. For comparability purposes, both sets of surveys were limited to two days and restricted to the same resident record sample. The study was intended to provide an indication of the effectiveness of PaCS in terms of quality, cost, and administration, as well as to identify areas of the tool in need of refinement.

Findings of the pilot test supported the continued refinement of the new survey process. PaCS and traditional surveyors tended to identify the same general problem areas (e.g., restorative care, nursing services) but differed in the specific provisions cited. PaCS surveyors more frequently noted direct care problems (e.g., aseptic techniques, ambulation), while traditional surveyors more often identified organizational or structural problems (e.g., nursing policies, maintenance of equipment). Early indications were that the PaCS survey could be completed in an hour's less time than the traditional survey, despite the greater amount of time spent on the facility tour and resident focused review under PaCS.

Surveyors and facility staff expressed a generally favorable reaction to the new system, particularly its emphasis on care review as opposed to paper compliance. Residents liked the idea of being more involved in the survey process although it was suggested that the length of the resident interviews needed to be reduced. Other recommendations produced by the first PaCS pilot testing included:

- Refine the PaCS forms to make them more concise and easier to follow through by individual resident.
- Provide more space for surveyor notes and commentary.
- Supplement the PaCs survey with a conventional review of infection control and sanitation.
- Surveyor training for PaCS should emphasize interviewing and observational skills.

Despite the small size of the sample, HCFA was very encouraged by the results of the pilot test and continued its efforts on a number of fronts to achieve eventual national implementation of a modified long-term care survey process. Program staff began working with the Office of Management and Budget (OMB) to obtain forms clearance to implement large-scale national testing of the PaCS process. At the same time, they continued refining the format and content of the survey instrument based on results of the initial testing as well as subsequent comments from the American Health Care Association (AHCA), the National Council of Health Centers (NCHC), and the American Association of Homes for the Aging (AAHA). The State of Rhode Island, which had been in the process of developing its own resident centered survey methodology, also took part in the refinement effort, and agreed to participate in an intensive evaluation of the PaCS instrument rather than continuing to develop its own tool. A second small scale pilot test of the PaCS process was scheduled in order to gain some experience with the refined instrument. HCFA than contracted with Rehabilitation Care Consultants, Inc., (RCC) to obtain an independent, professional assessment of the tool through a review of its components, observation of the pilot surveys and utilization of the tool by RCC staff.

Pilot Test 2

The PaCS model was field tested for a second time in Kentucky, Illinois and Pennsylvania from July 16 to August 8, 1984. Once again, Federal surveyors performed parallel PaCS/traditional surveys under controlled conditions to ensure comparability. The nine participating facilities were volunteers from the AAHA, AHCA and NCHC.

Results of the second pilot test were similar to the earlier findings in that the new survey process detected more resident care problems but was judged in need of further format changes to enhance ease of use. The PaCS surveyor, who had also taken part in the previous pilot test, consistently identified a greater number of overall deficiencies than the traditional surveyor (particularly in such resident-related areas as activities, social services, physician services, nutrition), indicating the possibility of a 2-3 survey learning curve for effective use of the new process. Although the second pilot test did not detect any time savings under the PaCS methodology, there was a clear redistribution of survey time to resident-oriented activities such as observation, interview and record review. (Note that the infection control and sanitation areas were more fully covered in this version of the tool, probably accounting for the lack of any time savings.) Surveyors made the following specific recommendations for improving the process:

- Reduce the length of the resident observation/interview form, if possible using a checklist format;
- Develop a better vehicle for summarizing findings; and

- Provide procedural guidelines applicable to each portion of the survey form.

Overall reaction from surveyors, facilities and residents continued to be quite favorable.

RCC's independent assessment of the new survey method was based on a detailed review of each of the components of the PaCS form and guidelines, observation of the instrument in use by a Federal surveyor, and RCC's own utilization of the PaCS forms. Citing the soundness of the PaCS concept, RCC stressed the need for a thorough and consistent training program to educate State surveyors in both the philosophy and implementation procedures of an outcome-oriented process. Other major recommendations stemming from RCC's descriptive analysis included:

- Decrease the cumbersome nature of the working instrument by separating all background and guideline type information;
- Add a one-page facility tour worksheet to the working instrument;
- Develop separate and expanded procedural guidelines applicable to each portion of the form, emphasizing the guidelines for the general facility tour;
- Expand eating assistance observation section to include crossmatching of diet cards and physician's order with actual meals served for a sample of residents;

- Include interviews with facility staff in the survey process; and
- Emphasize importance of surveyor judgment in selection of a targeted resident sample for indepth review.

RCC also made several recommendations related to the PaCS care guidelines, such as additional or amended care indicators addressing catheters, colostomies, decubitus and others. All of the above major recommendations and many of the more specific suggestions were eventually incorporated into the new LTC survey process.

Preparation for National Testing

Following the two encouraging pilot tests, HCFA staff began to prepare in earnest for large scale national testing of the PaCS process, pending departmental clearance of the survey forms. After making further refinements to PaCS based on surveyor and RCC recommendations from the second pilot test, they submitted the modified forms to OMB and requested approval to have States conduct PaCS surveys in nursing homes with particularly good compliance histories. Approval was requested to have the majority of States perform PaCS surveys in from 3-20 facilities, depending on the total number of facilities in the State, and to have surveyors complete a questionnaire regarding their impressions of the PaCS forms and process. This limited implementation was designed to foster surveyor and facility familiarity with the new resident-oriented process as well as to provide broad-based feedback about its strengths and problems. HCFA also requested permission to conduct a formal test of the PaCS process in Rhode Island, Tennessee and Connecticut, involving an extended group of facilities in each of these States.

During the latter part of 1984, as the PaCS forms made their way through the departmental clearance process, HCFA began to train surveyors in using the PaCS process. Surveyors from Rhode Island, Tennessee and Connecticut received training in October. During November and December 1984, HCFA staff conducted a series of training workshops to instruct surveyor representatives from all regional offices and states in using PaCS. Despite some opposition from surveyors who felt that the PaCS form was too long and cumbersome, there was strong overall support for the concept of resident-oriented surveys focusing on care delivery and outcomes rather than process. The executive Office of Management and Budget granted approval for States to begin using the PaCS forms and questionnaires in January 1985. Since that time, State surveyors have conducted over 350 PaCS surveys in the non-demonstration States.

Brown University is conducting a formal evaluation of the PaCS process in the three demonstration States of Rhode Island, Tennessee and Connecticut, where surveyors conducted PaCS surveys throughout 1985. Both RCC and the HCFA regional offices have conducted evaluations of the limited national testing, which took place in the other 47 States between February 1 and June 30, 1985.

The Brown University's New England Long Term Care Gerontology Center's evaluation is based on the result of extensive testing of the PaCS process during late 1984 and 1985 in the States of Rhode Island, Tennessee and Connecticut.

It focuses on the reliability and validity of the the new survey process and also examines such important sub-issues as resource utilization and surveyor and facility acceptance. Presented below is a brief summary of Brown's preliminary findings based on the partial data now available. HCFA now anticipates that final results of the evaluation will be available by March 1986.

1. In all three experimental States, the PaCS teams found a higher proportion of patient care deficiencies. Another significant finding was that the PaCS survey was equally or more effective than the traditional process in detecting environmental deficiencies. In terms of severity, Brown found that few condition level deficiencies were cited using either survey method. In two States, the PaCS teams cited more standards and critical deficiencies than did the traditional teams, while the reverse was true in one State.

2. In comparing the ability of the PaCS process to evaluate care in SNFs as opposed to ICFs, Brown found that the new process had more impact in the intermediate care setting. In ICFs, the PaCS team found 6.75 deficiencies per home, compared with 2.38 per home found under the traditional process. In SNFs, there was a less pronounced difference, with the PaCS team identifying 6.50 deficiencies per home, while the traditional found 5.67 per home. The final evaluation report will present further analysis in this area.

3. Unlike its predecessor, the new survey process has the potential to produce numerical norms and standards for determining when patient care problems warrant deficiency citations.

4. Overall, the preliminary resource utilization findings reflect the new methodology's potential for redirecting and eventually saving surveyor time while maintaining or increasing the efficiency of the survey. Although data on total survey time may be influenced by the varying team sizes across States and survey types, increase in the proportion of direct resident review time is a significant step forward.

5. Over two-thirds of a group of administrators/directors of nursing services reported that the PaCS process provided a better assessment of the quality of nursing home care. The group supported not only the concept of a resident-oriented survey but also the ability of the new survey process to successfully embody this concept, with over 80 percent stating that they'd prefer a PaCS survey to the traditional process.

6. Surveyors in the experimental States generally supported the patient-oriented survey process, but felt the forms needed refinement. They also felt that they were not sufficiently trained in the new process before implementation.

RCC's evaluation of the PaCS process was a primarily descriptive analysis based on the following sources of information:

- observation of PaCS surveys in nine sites across the country;
- analysis of responses from approximately 100 questionnaires completed by PaCS surveyors;
- review of 150 completed PaCS survey reports from 37 States.

RCC focused on how well surveyors were implementing the formative PaCS process and made recommendations regarding elements of the PaCS survey forms and procedures which need clarification or modifications. Its findings were highly supportive of the core PaCS process, including the execution of an in-depth facility tour, the use of targeted sampling, the in-depth review of that sample including observation, interview and record review, increased emphasis on dining and eating assistance issues, the drug pass observation, and the logical incorporation of these survey findings into deficiency citations via the PaCS summary form.

RCC's analysis of questionnaires submitted by PaCS surveyors, and the results of its observation of State survey teams using the process, yielded similar recommendations as to the main areas that needed to be addressed prior to full national implementation of the new survey process. These areas included:

1. Simplify the forms to make them easier to use;

2. Develop more specific procedural guidelines addressing how surveyors are to apply the method;

3. Most importantly, greatly emphasize the quality and amount of surveyor training in the new survey process.

Overall, surveyors indicated that they liked the PaCS concept but were not comfortable with the forms. Nearly half of the surveyors questioned indicated that the PaCS process was more effective than the traditional survey, identified problems that may have been undetected and enabled them to spend more time observing care provision and talking to residents. (The other half of the surveyors responded negatively or felt that PaCS had no impact either way.) However, approximately 70 percent of the respondents indicated that they had difficulty understanding or applying portions of the PaCS survey, particularly the tally sheet, observation/interview/record review (OIRR) form and the summary form. Reported problems in these areas were corroborated by RCC's findings from observing surveyors conducting the PaCS process. (Based on surveyor's comments, the forms have been refined and streamlined.)

RCC also reviewed completed PaCS survey reports in order to study several specific process-related issues and to assess the possible impact of variations in team size and composition and facility size and type on the utility of the process. RCC concluded that the PaCS forms, if used correctly, fostered a logical decision process and appropriate documentation to document surveyor decisions . However, surveyors were not generally using the process correctly, particularly the triggering mechanism, which RCC found not producing the anticipated results. They again stressed the need for extensive surveyor training focusing on correct usage of the forms. In terms of the survey team, RCC recommended that the team comprise between two and four surveyors, including one to two nurses. Other team members may be a dietician, pharmacist, sanitarian and/or social worker. The team size recommendation was based largely on the finding that smaller teams performed better in transferring problems found into deficiencies. No significant findings were reported with respect to variations in facility size and type. RCC did report that regardless of team or facility characteristics, almost all surveyors did an adequate job of targeting a resident sample..

Each HCFA regional office also contributed to evaluating the PaCS implementation through the performance of a limited number of Federal monitoring surveys following the States' PaCS surveys. Regional surveyors conducted both PaCS and traditional monitoring surveys, allowing them to simultaneously gain experience with the new survey process and to informally evaluate consistency between PaCS surveys and between the PaCS and traditional surveys. The regional findings provided further evidence that surveyors were uncomfortable with some of the PaCS forms (especially the tally sheet and the OIRR form) and reiterated surveyor concern over the adequacy of the training program. Analysis of the regional surveys also indicated that the total number of patient care deficiencies was very similar in State and Federal PaCS surveys. Both sets of surveyors identified the great majority of deficiencies in the areas of nursing services and dietetic services. A comparison of the State's PaCS surveys with the traditional Federal surveys revealed considerably more overall deficiencies being cited by the regional surveyors. However, more than two-thirds of the deficiencies cited under the traditional method can be classified as structural items, with the State surveyors actually identifying a greater number of direct care deficiencies than did the Federal surveyors. Regardless of survey method, there were no major differences between the States and the regions in terms of citing conditions of participation as out of compliance.

On October 31, 1985, HCFA published a NPRM in the Federal Register. It responded to a Federal court order requiring that by October 31, 1985, proposed regulations be published regarding a survey system that would enable the Secretary to better assess whether high quality care is actually being furnished to Medicaid recipients in nursing homes. The NPRM also indicated HCFA's intent to implement a new outcome - oriented survey process. This survey process, known as the Long Term Care survey as discussed above, will be implemented nationwide in April, 1986.

PART B

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938

"MEDICARE/MEDICAID SKILLED NURSING FACILITY AND INTERMEDIATE CARE FACILITY SURVEY REPORT"

PROVIDER NUMBER

VENDOR NUMBER

SURVEY DATE

FACILITY NAME AND ADDRESS (City, State, Zip Code)

SURVEYORS' NAMES	TITLES

SURVEY TEAM COMPOSITION

Indicate the Number of Surveyors According to Discipline:

A. ☐ Administrator
B. ☐ Nurse
C. ☐ Dietitian
D. ☐ Pharmacist
E. ☐ Records Administrator
F. ☐ Social Worker
G. ☐ Qualified Mental Retardation Professional
H. ☐ Life Safety Code Specialist
I. ☐ Laboratorian
J. ☐ Sanitarian
K. ☐ Therapist
L. ☐ Physician
M. ☐ National Institute of Mental Health
N. ☐ Other

Note: More than one discipline may be marked for surveyors qualified in multiple disciplines.

Indicate the Total Number of Federal Surveyors Onsite: ________

(Continued on Reverse)

PROVIDER NUMBER: ________ PATIENT CENSUS: ☐ Medicare ☐ Medicaid ☐ Other Total Residents ______

BATHING

___ Number of residents requiring assistance in bathing more than one part of body - or does not bathe self.

___ Number of residents requiring assistance in bathing only a single part (as back or disabled extremity) or bathes self completely.

___ Total*

DRESSING

___ Number of residents totally dressed by another person.

___ Number of residents needing assistance to dress self or remain partly dressed. (Exclude those residents totally dressed.)

___ Number of residents able to get clothes from closets and drawers - puts on clothes, outer garments, braces - manages fasteners - act of tying shoes is excluded.

___ Total*

TOILETING

___ Number of residents not toileted. (Use protective padding, catheter.)

___ Number of residents who must use bedpan or commode and/or receive assistance in getting to and using toilet.

___ Number of residents able to get to toilet - gets on and off toilet - cleans self - arranges clothes.

___ Total*

TRANSFERRING

___ Number of residents who need assistance in transferring to toilet and tub.

___ Number of residents who need assistance in moving in or out of bed and/or chair - (Exclude toilet, tub transfers).

___ Number of residents able to move in and out of bed independently and move in and out of chair independently - (may or may not be using mechanical supports).

___ Total*

CONTINENCE

___ Number of residents with indwelling or external catheters.

___ Number of residents with partial or total incontinence in urination or defecation - partial or total control by suppositories or enemas, regulated use of urinals and/or bed-pans.

___ Number of residents with urination and defecation entirely self-controlled.

___ Total*

FEEDING

___ Number of residents who receive nutrition parenteral feedings, e.g. tube, etc.

___ Number of residents who require assistance in act of eating.

___ Number of residents who get food from plate or its equivalent into mouth - (precutting of meat and preparation of food, as buttering bread, opening cartons, removing plate covers, etc., are excluded from evaluation).

___ Total*

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* Must equal total number of residents in facility.

___ Number of completely bedfast residents.

___ Number of chairbound residents.

___ Number of ambulatory residents (may use cane, walker or crutches).

___ Number of restrained residents (belt, vest, cuffs).

___ Number of confused or disoriented residents.

___ Number of residents with Decubiti.

___ Number of residents on individually written bowel and bladder retraining program.

___ Number of residents receiving special skin care.

___ Number of residents receiving intravenous therapy and/or blood transfusion.

___ Number of residents requiring no assistance in ADLs.

___ Number of residents on self-administration of drugs.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			GOVERNING BODY	
			SNF (405.1121) ☐ MET ☐ NOT MET	
			RESIDENT RIGHTS	
			SNF (405.1121(k)) ☐ MET ☐ NOT MET	
			[Indicators A thru L apply to SNFs.]	
			ICF (442.311) ☐ MET ☐ NOT MET	
			A. Information	
			1. The facility informs each resident, before or at the time of admission, of his rights and responsibilities.	
			2. The facility informs each resident, before or at the time of admission, of all rules governing resident conduct.	
			3. The facility informs each resident of amendments to their policies on residents' rights and responsibilities and rules governing conduct.	
			4. Each resident acknowledges in writing receipt of patients' rights information and any amendment to it.	
			5. The resident must be informed in writing of all services and charges for services.	
			6. The resident must be informed in writing of all changes in services and charges before or at the time of admission and on a continuing basis.	
			7. The resident must be informed of services not covered by Medicare or Medicaid and not covered in the basic rate.	
			B. Medical Condition and Treatment	
			1. Each resident is informed by a physician of his health and medical condition unless the physician decides that informing the resident is medically contraindicated.	

NAME OF FACILITY

YES	NO	N/A			EXPLANATORY STATEMENTS
			2.	Each resident is given an opportunity to participate in planning his total care and medical treatment.	
			3.	Each resident is given an opportunity to refuse treatment.	
			4.	Each resident gives informed, written consent before participating in experimental research.	
			5.	If the physician decides that informing the resident of his health and medical condition is medically contraindicated, the physician has documented this decision in the resident's medical record.	
			C.	Transfer and Discharge	
				Each resident is transferred to discharged only for:	
				1. Medical reasons.	
				2. His/her welfare or that of other residents.	
				3. Nonpayment except as prohibited by the Medicare or Medicaid program.	
			D.	Exercising Rights	
			1.	Each resident is encouraged and assisted to exercise his/her rights as a resident of the facility and as a citizen.	
			2.	Each resident is allowed to submit complaints and recommendations concerning the policies and services of the facility to staff or to outside representatives of the resident's choice or both.	
			3.	Such complaints are submitted free from restraint, coercion, discrimination, or reprisal.	

NAME OF FACILITY

YES	NO	N/A			EXPLANATORY STATEMENTS
			E.	Financial Affairs	
			1.	Residents are allowed to manage their own personal financial affairs.	
			2.	The facility establishes and maintains a system that assures full and complete accounting of residents' personal funds. An accounting report is made to each resident at least on a quarterly basis.	
			3.	The facility does not commingle resident funds with any other funds other than patient funds.	
			4.	If a resident requests assistance from the facility in managing his personal financial affairs, resident's delegation is in writing.	
			5.	The facility system of accounting includes written receipts for:	
				All personnal possessions and funds received by or deposited with the facility.	
				All disbursements made to or for the resident.	
			6.	The financial record must be available to the resident and his/her family.	
			F.	Freedom from Abuse and Restraints	
			1.	Each resident is free from mental and physical abuse.	
			2.	Chemical and physical restraints are only used when authorized by a physician in writing for a specified period of time or in emergencies.	
			3.	If used in emergencies, they are necessary to protect the resident from injury to himself or others.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			4. The use is authorized by a professional staff member identified in the written policies and procedures of the facility.	
			5. The use is reported promptly to the resident's physician by the staff member.	
			G. Privacy	
			1. Each resident is treated with respect, consideration and full recognition of his/her dignity and individuality.	
			2. Each resident is given privacy during treatment and care of personal needs.	
			3. Each resident's records, including information in an automatic data bank, are treated confidentially.	
			4. Each resident must give written consent before the facility releases information from his/her record to someone not otherwise authorized to receive it.	
			5. Married residents are given privacy during visits by their spouses.	
			6. Married residents are permitted to share a room.	
			H. Work	
			No resident may be required to perform services for the facility.	
			I. Freedom of Association and Correspondence	
			1. Each resident is allowed to communicate, associate and meet privately with individuals of his choice unless this infringes upon the rights of another resident.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			2. Each resident is allowed to send and receive personal mail unopened.	
			J. Activities Each resident is allowed to participate in social, religious, and community group activities.	
			K. Personal Possessions Each resident is allowed to retain and use his personal possessions and clothing as space permits.	
			L. Delegation of Rights and Responsibilities ICF 442.312 ☐ MET ☐ NOT MET	
			1. All the rights and responsibilities of a resident pass to the resident's guardian, next of kin or sponsoring agency or agencies if the resident is adjudicated incompetent under State law or is determined by his physician to be incapable of understanding his rights and responsibilities.	
			2. Physician determinations of incapability and the specific reasons thereof are recorded by the physician in the resident's record.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			STATUS CHANGE NOTIFICATIONS SNF (405.1121(j)) ☐ MET ☐ NOT MET ICF (442.307) ☐ MET ☐ NOT MET 1. The facility notifies the resident's attending physician and other responsible persons in the event of an accident involving the resident, or other significant change in the resident's physical, mental, or emotional status, or patient charges, billings, and related administrative matters. 2. Except in a medical emergency, a resident is not transferred or discharged, nor is treatment altered radically, without consultation with the resident or, if the resident is incompetent, without prior notification of next of kin or sponsor.	

NAME OF FACILITY

YES	NO	N/A	PHYSICIANS' SERVICES	EXPLANATORY STATEMENTS

PHYSICIANS' SERVICES

SNF (405.1123) ☐ MET ☐ NOT MET

A. Medical Findings and Orders at Time of Admission

SNF (405.1123(a)) ☐ MET ☐ NOT MET

1. There is made available to the facility prior to or at the time of admission, resident information which includes current medical findings, diagnoses, and orders from a physician for immediate care of the resident.

2. Information about the rehabilitation potential of the resident and a summary of prior treatment are made available to the facility at the time of admission or within 48 hours thereafter.

B. Resident Supervision by Physician

SNF (405.1123(b)) ☐ MET ☐ NOT MET

ICF (442.346) ☐ MET ☐ NOT MET

[Indicators B and C apply to ICFs.]

1. Every resident must be under the supervision of a physician.

2. A physician prescribes a planned regimen of care based on a medical evaluation of each resident's immediate and long-term care needs.

3. A physician is available to provide care in the absence of any resident's attending physician.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			4. Medical evaluation is done within 48 hours of admission unless done within 5 days prior to admission. Exception: Not required for ICF residents.	
			5. Each resident is seen by their attending physician at least once every 30 days for the first 90 days after admission. Exception: ICF Residents must be seen every 60 days unless otherwise justified and documented by the attending physician).	
			6. Each resident's total program of care including medications and treatments is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days and revised as necessary. Exception: Only medications must be reviewed quarterly for ICF Residents.	
			7. Progress notes are written and signed by the physician at the time of each visit, and all orders are signed by the physician. Exception: Not required for ICF residents.	
			8. Alternate physician visit schedules that exceed a 30-day schedule adopted after the 90th day following admission are justified by the attending physician in the medical record. These visits	

YES	NO	N/A		EXPLANATORY STATEMENTS
			cannot exceed 60 days or apply to patients who require specialized rehabilitation schedules. Exception: ICF Residents must be seen every 60 days unless justified otherwise and documented by the attending physician.	
			C. Emergency Services SNF (405.1123(c)) ☐ MET ☐ NOT MET Emergency services from a physician are available and provided to each resident who requires emergency care.	

NAME OF FACILITY

YES	NO	N/A	NURSING SERVICES	EXPLANATORY STATEMENTS
			SNF (405.1124) ☐ MET ☐ NOT MET	
			ICF (442.338) ☐ MET ☐ NOT MET Indicators A thru E apply to ICFs except where noted.	
			A. The facility provides nursing services which are sufficient to meet nursing needs of all residents all hours of each day. Indicators A and B apply to SNFs. SNF (405.1124(c)) ☐ MET ☐ NOT MET 1. Each resident receives all treatments, medications and diet as prescribed. Deviations are reported and appropriate action is taken. 2. Each resident receives daily personal hygiene as needed to assure cleanliness, good skin care, good grooming, and oral hygiene taking into account individual preferences. Residents are encouraged to engage in self care activity. 3. Each resident receives care necessary to prevent skin breakdown. 4. Each resident with a decubitus receives care necessary to promote the healing of the decubitus including proper dressing. 5. When residents require restraints the application is ordered by the physician, applied properly, and released at least every 2 hours. 6. Each resident with incontinence is provided with care necessary to encourage continence including frequent toileting and opportunities for rehabilitative training.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

7. Each resident with a urinary catheter receives proper routine care including periodic evaluation.

8. Each resident receives proper care for the following needs:
    - Injections
    - Parenteral Fluids
    - Colostomy/Ileostomy
    - Respiratory Care
    - Tracheostomy Care
    - Suctioning
    - Tube Feeding

9. Infection Control Techniques are properly carried out in the provision of care to each resident.

10. Proper nursing and sanitary procedures and techniques are used when medications are given to residents.

11. Adequate resident care supplies are available for providing treatments.

B. Twenty-Four Hour Nursing Service

1. Nursing personnel, including registered nurses, licensed practical (vocational) nurses, nurse aides, orderlies, and ward clerks, are assigned duties consistent with their education and experience, and based on the characteristics of the resident load.

2. Weekly time schedules are maintained and indicate the number and classifications of nursing personnel including relief personnel, who worked on each unit for each tour of duty.

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

(If a distinct part certification, in an ICF or uncertified facility, show the staffing for the DP, and if appropriate, the entire facility and explain any sharing of nursing personnel.)

Exception: Not required for ICFs.

3. There is a sufficient number of nursing staff available to meet the total needs of all residents.

4. There is a registered nurse on the day tour of duty 7 days a week.

Exception: Not required for ICF residents.

C. Charge Nurse

SNF (405.1124(b)) ☐ MET ☐ NOT MET

1. A registered nurse or a qualified licensed practical (or vocational) nurse is designated as charge nurse by the director of nursing for each tour of duty.

Exception: Not required for ICFs.

2. The director of nursing services does not serve as charge nurse in a facility with an average daily total occupancy of 60 or more residents.

Exception: Not required for ICFs.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			LIST THE NUMBER OF FULL-TIME EQUIVALENTS OF RN'S, LPN'S, AIDES/ORDERLIES ASSIGNED TO NURSING DUTY FROM THE LAST 3 COMPLETE WEEKS. (NOTE ONLY ACTUAL STAFF ON DUTY.)	

SHIFT		DAY 1			DAY 2			DAY 3			DAY 4			DAY 5			DAY 6			DAY 7		
		RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DP	DAY																					
EN-TIRE FAC.																						
DP	EVEN-ING																					
EN-TIRE FAC.																						
DP	NIGHT																					
EN-TIRE FAC.																						

SHIFT		DAY 1			DAY 2			DAY 3			DAY 4			DAY 5			DAY 6			DAY 7		
		RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DP	DAY																					
EN-TIRE FAC.																						
DP	EVEN-ING																					
EN-TIRE FAC.																						
DP	NIGHT																					
EN-TIRE FAC.																						

NAME OF FACILITY

YES	NO	N/A

EXPLANATORY STATEMENTS

SHIFT		DAY 1			DAY 2			DAY 3			DAY 4			DAY 5			DAY 6			DAY 7		
		RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DP	DAY																					
ENTIRE FAC.																						
DP	EVENING																					
ENTIRE FAC.																						
DP	NIGHT																					
ENTIRE FAC.																						

STAFFING PATTERN WORKSHEETS DAY OF SURVEY (OPTIONAL)

ENTIRE FACILITY STAFFING PATTERN (DAY OF SURVEY)

		RN	PN	A
DAY	REPORT			
	ACTUAL			
EVENING	REPORT			
	ACTUAL			
NIGHT	REPORT			
	ACTUAL			

UNIT STAFFING PATTERN WORKSHEET (DAY OF SURVEY)

	UNIT ___			UNIT ___			UNIT ___			UNIT ___			UNIT ___		
	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DAY															
EVENING															
NIGHT															
CENSUS															

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

D. Rehabilitative Nursing Services are performed daily, and recorded for those residents who require such service.

SNF (405.1124(e)) ☐ MET ☐ NOT MET

1. Each resident receives rehabilitative nursing care to promote maximum physical functioning to prevent immobility, deformities, and contractures.

2. There is an ongoing evaluation of each patient's rehabilitative nursing needs. This may include;

   (a) Range of motion, ambulation, turning and positioning and other activities;

   (b) Assistance and instruction in the activities of daily living such as feeding, dressing, grooming, oral hygiene and toilet activities;

   (c) Remotivation therapy and/or reality orientation when appropriate.

3. These activities are coordinated with other patient care services.

E. Awareness of nutritional needs and fluid intake of residents and prompt assistance where necessary in feeding residents.

SNF (405.1124(f)) ☐ MET ☐ NOT MET

1. Each resident is provided with the amount of food and fluid on a daily basis necessary to maintain their appropriate minimum average weight. Between meal feedings are offered and the amount consumed is observed. Daily food and fluid intake is observed and encouraged.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

2. Each resident needing assistance in eating or drinking is provided prompt assistance. Specific self-help devices are available when necessary.

3. Deviations from normal food and fluid intake are recorded and reported to the charge nurse and the attending physician.

F. Administration of Drugs

SNF (405.1124(g)) ☐ MET ☐ NOT MET

ICF (442.337) ☐ MET ☐ NOT MET

1. The resident is identified prior to administration of a drug.

2. Drugs and biologicals are administered as soon as possible after doses are prepared.

3. Administered by same person who prepared the doses for administration except under single unit dose package distribution systems.

Exception: ICF residents may self administer medication with their physician's permission.

G. Conformance with Physician Drug Orders

SNF (405.1124(h)) ☐ MET ☐ NOT MET

ICF (442.334) ☐ MET ☐ NOT MET

Drugs are administered in accordance with written orders of the attending physician.

NAME OF FACILITY

YES	NO	N/A	DIETETIC SERVICES	EXPLANATORY STATEMENTS
			SNF (405.1125) ☐ MET ☐ NOT MET	
			A. Menus and Nutritional Adequacy	
			SNF (405.1125(b)) ☐ MET ☐ NOT MET	
			ICF (442.332(a)(1)) ☐ MET ☐ NOT MET	
			Menus are planned and followed to meet the nutritional needs of each resident in accordance with physicians' orders and, to the extent medically possible, based on the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.	
			B. Therapeutic Diets	
			SNF (405.1125(c)) ☐ MET ☐ NOT MET	
			ICF (442.332(b)(1)(2)) ☐ MET ☐ NOT MET	
			1. Therapeutic diets are prescribed by the attending physician.	
			2. Therapeutic menus are planned in writing, prepared, and served as ordered with supervision from the dietition and advice from the physician whenever necessary.	
			Number of Regular Diets	
			Number of Therapeutic Diets	
			Number of Mechanically Altered Diets	
			Number of Tube Feedings	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

C. Preparation

SNF (405.1125(e)) ☐ MET ☐ NOT MET

ICF (442.332(a)(2)) ☐ MET ☐ NOT MET

1. Food is prepared by methods that conserve its nutritive value and flavor.
2. Meals are palatable, served at proper temperatures. They are cut, ground, chopped, pureed or in a form which meets individual resident needs.
3. If a resident refuses food served, appropriate substitutes of similar nutritive value are offered.

D. Frequency

SNF (405.1125.(d)) ☐ MET ☐ NOT MET

ICF (442.331(a)) ☐ MET ☐ NOT MET

1. At least three meals are served daily at regular hours with not more than a 14-hour span between a substantial evening meal and breakfast.
2. To the extent medically possible, bedtime nourishments are offered to all residents.

Exception: Not required for ICF residents.

NAME OF FACILITY

YES	NO	N/A	E. Staffing	EXPLANATORY STATEMENTS
			SNF (405.1125.(a)) ☐ MET ☐ NOT MET Food service personnel are on duty daily over a period of 12 or more hours.	

NAME OF FACILITY

YES	NO	N/A	SPECIALIZED REHABILITATIVE SERVICES	EXPLANATORY STATEMENTS
			SNF (405.1126) ☐ MET ☐ NOT MET	
			SNF (405.1126(b)) ☐ MET ☐ NOT MET Indicators A thru C apply to SNFs.	
			A. Plan of Care ICF (442.343(e)(1)(2)) ☐ MET ☐ NOT MET Rehabilitative services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapists(s) and the nursing service.	
			B. Therapy ICF (442.343(a)(c)(d)) ☐ MET ☐ NOT MET Therapy is provided according to orders of the attending physician in accordance with accepted professional practices by qualified therapists or qualified assistants.	
			C. Progress ICF (442.343(f)) ☐ MET ☐ NOT MET 1. A report of the patient's progress is communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services. Exception: ICF resident's progress must be reviewed regularly.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			2. The patient's progress is thereafter reviewed regularly, and the plan of rehabilitative care is reevaluated as necessary, but at least every 30 days, by the physician and the therapist. Exceptions: ICF residents' plans must be revised as necessary.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			PHARMACEUTICAL SERVICES SNF (405.1127) ☐ MET ☐ NOT MET	
			A. Supervision SNF (405.1127(a)) ☐ MET ☐ NOT MET ICF (442.336(a)(b)) ☐ MET ☐ NOT MET The pharmacist reviews the drug regimen of each patient at least monthly and reports any irregularities to the medical director and administrator. Exception: A registered nurse may be utilized to perform this review for ICF residents. Also, the attending or staff physician must review medications quarterly.	
			B. Labeling of Drugs and Biologicals SNF (405.1127(c)) ☐ MET ☐ NOT MET ICF (442.333(a)) ☐ MET ☐ NOT MET The labeling of drugs and biologicals is based on currently accepted professional principles and includes the appropriate accessary and cautionary instructions as well as an expiration date when applicable.	

NAME OF FACILITY

YES	NO	N/A	LABORATORY AND RADIOLOGIC SERVICES	EXPLANATORY STATEMENTS
			SNF (405.1128) ☐ MET ☐ NOT MET	
			SNF (405.1128(a)) ☐ MET ☐ NOT MET	
			A. Provision of Services	
			1. All services are provided only on the orders of a physician.	
			2. The attending physician is notified promptly of diagnostic findings.	
			3. Signed and dated reports of a clinical laboratory, X-ray and other diagnostic services are filed with the patient's medical record.	

NAME OF FACILITY

YES	NO	N/A	SOCIAL SERVICES	EXPLANATORY STATEMENTS
			SNF (405.1130) ☐ MET ☐ NOT MET	
			SNF (405.1130)(a)) ☐ MET ☐ NOT MET Indicators A and B apply to SNFs.	
			A. Plan ICF (442.344(d)) ☐ MET ☐ NOT MET The medically related social and emotional needs of the resident are identified.	
			B. Provision of Services ICF (442.344(a)(b)) ☐ MET ☐ NOT MET 1. Services are provided to meet the social and emotional needs by the facility or by referral to appropriate social agencies. 2. If financial assistance is indicated, arrangements are made promptly for referral to an appropriate agency.	

NAME OF FACILITY

YES	NO	N/A	ACTIVITIES	EXPLANATORY STATEMENTS
			SNF (405.1131) ☐ MET ☐ NOT MET	
			A. Provision of Services	
			SNF (405.1131(b)) ☐ MET ☐ NOT MET	
			ICF (442.345(a)(c)(d)) ☐ MET ☐ NOT MET	
			1. An ongoing program of meaningful activities is provided based on identified needs and interests of each resident. It is designed to promote opportunities for engaging in normal pursuits, including religious activities of their choice, if any.	
			2. Unless contraindicated by the attending physicians all residents are encouraged to participate in activities program.	
			3. The activities promote the physical, social and mental well-being of the residents.	
			4. Equipment is maintained in good working order.	
			5. Supplies and equipment are available.	

NAME OF FACILITY

YES	NO	N/A	PATIENT CARE MANAGEMENT	EXPLANATORY STATEMENTS
			SNF (405.1124(d)) ☐ MET ☐ NOT MET	
			ICF (442.341) ☐ MET ☐ NOT MET	
			A. Each resident's needs are addressed in a written plan of care which demonstrates that the plans of all services are integrated, consonant with the physician's plan of medical care, and is implemented shortly after admission.	
			B. Each professional service identifies needs, goals, plans, and evaluates the effectiveness of interventions, plus institutes changes in the plan of care in a timely manner.	

NAME OF FACILITY

YES	NO	N/A	TRAINING	EXPLANATORY STATEMENTS
			SNF (405.1121(h) ☐ MET ☐ NOT MET ICF (442.314) ☐ MET ☐ NOT MET 1. Facility staff are knowledgeable about the problems and needs of the aged, ill, and disabled. 2. Facility staff practice proper techniques in providing care to the aged, ill, and disabled. 3. Facility staff practice proper technique for prevention and control of infection, fire prevention and safety, accident prevention, confidentiality of resident information, and preservation of resident dignity, including protection of privacy and personal and property rights.	

NAME OF FACILITY

YES	NO	N/A	MEDICAL RECORDS	EXPLANATORY STATEMENTS
			SNF (405.1132) ☐ MET ☐ NOT MET	
			Content	
			SNF (405.1132(c)) ☐ MET ☐ NOT MET	
			ICF (442.318(a)(c)) ☐ MET ☐ NOT MET	
			1. The medical record contains sufficient information to identify the resident clearly, to justify diagnoses and treatment, and to document results accurately.	
			2. The medical record contains the following information.	
			a. Identification information	
			b. Admission data including past medical and social history	
			c. Transfer form, discharge summary from any transferring facility	
			d. Report of resident's attending physician	
			e. Report of physical examinations	
			f. Reports of physicians' periodic evaluations and progress notes	
			g. Diagnostic reports and therapeutic orders	
			h. Reports of treatments	
			i. Medications administered	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			j. An overall plan of care setting forth goals to be accomplished through each service's designed activities, therapies and treatments	
			k. Assessments and goals of each service's plan of care	
			l. Treatments and services rendered	
			m. Progress notes	
			n. All symptoms and other indications of illness or injury including date, time and action taken regarding each problem.	

NAME OF FACILITY

YES	NO	N/A	TRANSFER AGREEMENT	EXPLANATORY STATEMENTS
			SNF (405.1133) ☐ MET ☐ NOT MET	
			SNF (405.1133(a)) ☐ MET ☐ NOT MET	
			ICF (442.316) ☐ MET ☐ NOT MET	
			A. Whenever the attending physician determines that a transfer is medically appropriate between a hospital or a facility providing more specialized care and the nursing facility, admission to the new facility shall be effected in a timely manner.	
			B. Information necessary for providing care and treatment to transferred individuals is provided.	

NAME OF FACILITY

YES	NO	N/A	PHYSICAL ENVIRONMENT	EXPLANATORY STATEMENTS
			SNF (405.1134) ☐ MET ☐ NOT MET	
			A. Nursing Unit: SNF (405.1134(d)) ☐ MET ☐ NOT MET 1. The unit is properly equipped for preparation and storage of drugs and biologicals. 2. There is adequate space for utility and storage. 3. The unit is equipped to register resident calls with a functioning communication system from resident areas including resident rooms and toilet and bathing facilities.	
			B. Dining and Activities Area: SNF (405.1134(g)) ☐ MET ☐ NOT MET ICF (442.329) ☐ MET ☐ NOT MET 1. The facility provides one or more clean, orderly and appropriately furnished rooms of adequate size, designated for resident dining and resident activities. 2. Dining and activity rooms are well lighted and ventilated. 3. Any multipurpose room used for dining and resident activities has sufficient space to accommodate all activities and prevent their interference with each other.	

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

SNF (405.1134(e)) ☐ MET ☐ NOT MET

Indicators C and D apply to SNFs.

C. Resident Rooms:

ICF (442.325) ☐ MET ☐ NOT MET

1. Single resident rooms have at least 100 square feet.
2. Multiple resident rooms have no more than four residents and at least 80 square feet per resident.
3. Each room is equipped with or conveniently located near toilet and bathing facilities.
4. There is capability of maintaining privacy in each.
5. There is adequate storage space for each resident.
6. There is a comfortable and functioning bed and chair plus a functioning cabinet and light.
7. Personal expression is allowed.
8. The resident call system functions in resident rooms.
9. Each room is designed and equipped for adequate nursing care and the comfort and privacy of the residents.
10. Each room is at or above grade level.
11. Each room has direct access to a corridor and outside exposure.

Exception: Not required for ICF residents.

D. Toilet and Bath Facilities

ICF (442.326) ☐ MET ☐ NOT MET

1. Facilities are clean, sanitary and free of odors.
2. Facilities have safe and comfortable hot water temperatures.
3. Facilities have capability of maintaining privacy.
4. Facilities have grab bars and other safeguards against slipping.
5. Facilities have fixtures in good condition.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			E. Social Service Area: SNF (405.1130(b)) ☐ MET ☐ NOT MET ICF (442.344(c)) ☐ MET ☐ NOT MET 1. Capability to ensure privacy for social service interviewing. 2. Adequate space for clerical and interviewing functions. 3. Easily accessible to residents and staff.	
			F. Therapy Areas: SNF (405.1126(a)) ☐ MET ☐ NOT MET ICF (442.328(a)) ☐ MET ☐ NOT MET 1. Space is adequate for proper use of equipment by all residents receiving treatments. 2. Equipment is safe and in proper working condition.	
			G. Facilities for Special Care SNF (405.1134(f)) ☐ MET ☐ NOT MET ICF (442.328(b)) ☐ MET ☐ NOT MET 1. Single rooms with private toilet and handwashing facilities are available for isolating residents. 2. Precautionary signs are used to identify these rooms when in use.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

ICF (442.324) ☐ MET ☐ NOT MET

Indicators H and I apply to ICFs.

H. Common Resident Areas:

SNF (405.1134(j)) ☐ MET ☐ NOT MET

1. All common resident areas are clean, sanitary and free of odors.
2. Provision is made for adequate and comfortable lighting levels in all areas.
3. There is limitation of sounds at comfort levels.
4. A comfortable room temperature is maintained.
5. Adequate ventilation through windows or mechanical means or a combination of both.
6. Corridors are equipped with firmly secured handrails on each side.
7. Staff are aware of procedures to ensure water to all essential areas in the event of loss of normal supply.

I. Maintenance of Building and Equipment:

SNF (405.1134(i)) ☐ MET ☐ NOT MET

1. The interior and exterior of the building are clean and orderly.
2. All essential mechanical and electrical equipment is maintained in safe operating condition.
3. Sufficient storage space is available and used for equipment to ensure that the facility is orderly and safe.
4. Resident care equipment is clean and maintained in safe operating condition.

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

ICF (442.331) ☐ MET ☐ NOT MET

Indicators J and K apply to ICFs.

J. Dietetic Service Area:

SNF (405.1134(h)) ☐ MET ☐ NOT MET

1. Kitchen and dietetic service areas are adequate to insure proper, timely food services for all patients.
2. Kitchen areas are properly ventilated, arranged, and equipped for storage and preparation of food as well as for dish and utensil cleaning, and refuse storage and removal.

K. Dietetic Sanitary Conditions

SNF (405.1125(f)(g)) ☐ MET ☐ NOT MET

1. Dietetic service personnel practice hygienic food handling techniques.
2. Food is stored, refrigerated, prepared, distributed, and served under sanitary conditions.
3. Waste is disposed of properly.

L. Emergency Power

SNF (405.1134(b)) ☐ MET ☐ NOT MET

1. An emergency source of electrical power necessary to protect the health and safety of residents is available in the event the normal electrical supply is interrupted.
2. Emergency power is adequate at least for lighting in all means of egress; equipment to maintain fire detection, alarm, and extinguishing systems; and life safety support systems.
3. Emergency power is provided by an emergency electrical generator located on the premises where life support systems are used.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			INFECTION CONTROL SNF (405.1135) ☐ MET ☐ NOT MET	
			A. Infection Control SNF (405.1135(b)) ☐ MET ☐ NOT MET Aseptic and isolation techniques are followed by all personnel.	
			B. Sanitation SNF (405.1135(c)) ☐ MET ☐ NOT MET The facility maintains a safe, clean, and orderly interior.	
			C. Linen SNF (405.1135(d)) ☐ MET ☐ NOT MET 1. The facility has available at all times a quantity of linen essential for proper care and comfort of residents. 2. Linens are handled; stored, processed, and transported in such a manner as to prevent the spread of infection.	
			D. Pest Control SNF (405.1135(e)) ☐ MET ☐ NOT MET The facility is maintained free from insects and rodents.	

NAME OF FACILITY

YES	NO	N/A	DISASTER PREPAREDNESS	EXPLANATORY STATEMENTS
			SNF (405.1136) ☐ MET ☐ NOT MET	
			SNF (405.1136(a)) ☐ MET ☐ NOT MET ICF (442.313) ☐ MET ☐ NOT MET Indicators A and B apply to ICFs. A. Disaster Plan 1. Facility staff are aware of plans, procedures to be followed for fire, explosion or other disaster. 2. Facility staff are knowledgeable about evacuation routes. 3. Facility staff are aware of their specific responsibilities in regard to evaluation and protection of residents. 4. Facility staff are aware of methods of containing fire.	
			B. Drills SNF (405.1136(b)) ☐ MET ☐ NOT MET 1. All employees are trained, as part of their employment orientation in all aspects of preparedness for any disaster. 2. Facility staff participate in ongoing training and drills in all procedures so that each employee promptly and correctly carries out a specific role in case of a disaster.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

TOUR NOTES WORKSHEET

PROVIDER NUMBER

SURVEY DATE

INSTRUCTIONS

1. *Note care and problems in care on all units.*
2. *Report deficiencies directly to survey report form or evaluate further during indepth sample review.*
3. *Select residents for indepth review.*
4. *Select a proportionate number from each section.*

INDEPTH SAMPLE			
Facility Bed Size	*<60*	*60-200*	*200+*
Sample Size	*5*	*10%*	*30*

OBSERVE RESIDENTS FOR THE FOLLOWING CARE PROBLEMS

GROOMING/PERSONAL HYGIENE

POSITIONING

ASSISTIVE DEVICES

AMBULATION

RESTRAINTS

HYDRATION

INFECTION CONTROL

PATIENT RIGHTS

OTHER

FORM HCFA-521 (11-85)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

RESIDENTS SELECTED FOR INDEPTH REVIEW

PROVIDER NUMBER

SURVEY DATE

	RESIDENT NAME (TARGETED)*	ROOM NUMBER	REASON FOR SELECTION
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

FORM HCFA-520 (11-85)

* NOTE IF ICF OR SNF RESIDENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

DRUG PASS WORKSHEET

PROVIDER NUMBER

SURVEY DATE

ERROR RATE ☐

INSTRUCTIONS

1. *Perform Drug Pass Observations on 20 Residents.*
2. *Record Observation of each Opportunity.*
3. *Compare Observation Notes with Physician Orders.*
4. *Calculate and Note Error Rate.*
5. *Note Defeciencies on Survey Report Form.*

DEFICIENCY FORMULA

1. *One or more Significant Errors = Deficiency*
2. $\frac{\text{Significant + Non-significant}}{\text{Doses Given + Doses Ordered But Not Given}} \times 100 \quad \geq 5\% = \text{Deficiency}$

IDENTIFIER	POUR	PASS	RECORD
RESIDENTS FULL NAME, ROOM NUMBER, TIME	DRUG PRESCRIPTION NAME, DOSE AND FORM	OBSERVATION OF ADMINISTRATION	DRUG ORDER WRITTEN AS: *(IF DIFFERS FROM ADMINIS ONLY)*

FORM HCFA-522 (11-85)

DRUG ERROR CALCULATION
(page 10-11 SOM excerpt)

How to Calculate a Medication Error Rate—In calculating the percentage of errors, the numerrator in the ratio is the total number of errors that you observe, both significant and non-significant. The denominator is all the doses you observed being administered **plus** the doses ordered but not administered. The equation for calculating a medication error rate is as follows:

$$\text{Medication Error Rate} = \frac{\text{Number of errors observed}}{\text{Opportunities for errors}} \times 100$$

Where: Opportunities for errors equals the number of doses administered **plus** the number of doses ordered but not administered.

Comments

For example, you observed the administration of drugs to 20 patients. There were a total of 47 drugs administered (47 opportunities for errors). At the completion of the reconciliation of your Observations with the physicians' orders, you find that three medication errors were made in administration and one medication was omitted (ordered but not administered). The omitted dose is included in both the numerator and the denominator. Therefore, following the above formula, your equation would be as follows:

$$\frac{3 + 1}{47 + 1} \times 100 = 8.3\%$$

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

DINING ASSISTANCE WORKSHEET

PROVIDER NUMBER

SURVEY DATE

INSTRUCTIONS

TASKS 1. Observe Dining Area.
2. Note Meals Served/Review Physicians Orders.
3. Note Assistance Provided.
4. Note Deficiencies on Survey Summary Form.

►►*SAMPLE A MINIMUM OF FIVE (5) RESIDENTS◄◄

1. DINING AREA AND MEALS

a. Size does not restrict movement.

b. Accommodate all patients.

c. Cleanliness.

d. Adequate/comfortable lighting.

e. Adequate/comfortable ventilation.

2. SERVING OF MEALS *

a. Number of meals/time span between meal.

b. Conformance to physicians order.

c. Nutritional adequate.

d. Adequacy of portions.

e. Residents eat approximately 75% of meals.

f. Puree dishes served individually.

g. Food cut, chopped or ground for individual resident needs.

h. Acceptable taste.

i. Proper temperature.

j. Plates covered.

2. SERVING OF MEALS *(continued)*

k. Served promptly.

l. Residents ready for meal when served.

m. Attractive.

n. Utensils available.

o. Functional trays for bedfast residents.

p. Salt, pepper, sugar, other condiments on resident's trays unless contraindicated.

q. Medically able residents eating in dining area.

r. Bedtime nourishment offered.

3. SUPERVISION OF RESIDENT NUTRITION

a. Prompt assistance.

b. Proper assistance (spoon-feeding; supervision or instruction to develop eating skills).

c. Courteous and unhurried assistance.

d. Self-help devices present (straws, easy grip utensils, special cup, etc.).

e. Intake recorded/deviations from normal are reported.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO 0938-

OBSERVATION / INTERVIEW RECORD REVIEW WORKSHEET

PROVIDER NUMBER	SURVEY DATE	OBSERVATION/INTERVIEW OF: (RESIDENT IDENTIFIES)

INSTRUCTIONS

1. Observe each resident in sample to identify ADL needs and potential problems. Check appropriate blocks
2. Interview only residents in sample who are capable and willing.
3. Review each resident's record to ensure assessments, plans, interventions and evaluations are appropriate and current.
4. Note deficiencies on survey report form after reviewing all residents in sample.

NURSING NEEDS

ADL'S
☐ Bathing
☐ Dressing
☐ Toileting
☐ Transferring
☐ Continence
☐ Feeding

SKIN
☐ Tears/Wounds
☐ Ulcers
☐ Rashes
☐ Flaking
☐ Scaling
☐ Red Area

DECUBITUS
☐ Grade
☐ Foul Odor
☐ Draining
☐ Dressing
☐ Unclean
☐ Not Dry
☐ Not Intact
☐ Poor Technique

DRESSINGS
☐ Unclean
☐ Not Dry
☐ Not Intact
☐ Foul Odor
☐ Poor Technique

GROOMING/HYGIENE
☐ Eyes/Ears/Mouth
☐ Oral/Dental Hygiene
☐ Foot Care
☐ Facial Hair
☐ Hair/Scalp
☐ Nails
☐ Clothing
☐ Shoes/Slippers
☐ Odors

POSITIONING
☐ Contracted Extremities
☐ Improper Position
☐ No Protective Device
☐ ROM Improper
☐ Lack of Turning as Needed
☐ Schedule Not Present
☐ Improper Techniques
☐ Aseptic/Other

RESTRAINTS
☐ Type
☐ Inappropriate Application
☐ Improper Body Alignment/Support
☐ Not Released/Exercised Every 2 Hours
☐ Chemically Restrained

INJECTIONS
☐ Site Red/Swollen
☐ Improper Technique
☐ Resident Reacts

PARENTERAL FLUID/IV'S
☐ Rate Incorrect/Stopped
☐ Site Red/Swollen
☐ Dressing Unclean
☐ Unsafe Splint
☐ Improper Label
☐ Outdated Solution
☐ No I/O Recording

BOWEL/BLADDER
☐ Not Routinely Toileted
☐ Commode Not Available
☐ Schedule Not Available

CATHETER
☐ Inappropriate
☐ Poor Drainage
☐ Drainage System Open
☐ No Urine in Bag
☐ Urine Leaking
☐ Abdomen Distended
☐ Tubing Not Clean
☐ No Intake/Output Record
☐ Supply Storage Unclean

COLOSTOMY/ILEOSTOMY
☐ Not Well Regulated
☐ Odors
☐ Diarrhea/Constipation
☐ Site Red/Irritated

RESPIRATORY
☐ Congested/Short Breath
☐ IPPB Not Available
☐ Oxygen Not Available
☐ Improper Equipment Use

TRACHEOSTOMY
☐ Site Red/Swollen
☐ Obstructed
☐ Unclean
☐ Improper Suctioning
☐ Equipment Not Available

SUCTIONING
☐ Audible Rales
☐ Labored Breathing
☐ Drainage
☐ Equipment Not Available

DIETARY NEEDS
☐ Over/Under weight
☐ Dehydrated
☐ Edema
☐ Emaciated
☐ Dull/Dry Hair
☐ Swollen/Red Tongue
☐ Bleeding Gums
☐ Cracked Lips
☐ Inability to Chew
☐ Swallowing Problem
☐ Pallor

TUBE FEEDING
☐ Nutrition Inadequate
☐ Poorly Tolerated
☐ Vomits
☐ Dehydrated
☐ Over/Underweight
☐ Diarrhea/Constipation
☐ Poor Skin Condition
☐ Poor Mouth Condition
☐ Improper Technique

OTHER
☐
☐
☐
☐
☐

REHABILITATION NEEDS
☐ Cannot Communicate
☐ Ineffective Use of Assistive Device
☐ Improper Equipment Use
☐ Improper Technique
☐ Equipment Inadequate

SOCIAL SERVICE NEEDS
☐ Not Oriented
☐ Not Able to Converse
☐ Uncooperative/Disrupts
☐ Withdrawn
☐ Anxious
☐ Confused
☐ Lonely
☐ Vision/Hearing Needs
☐ Mentally Retarded

PATIENT RIGHTS
☐ Privacy Not Maintained
☐ Staff Not Courteous
☐ Not Informed of Rights
☐ Mental/Physical Abuse
☐ Cannot Exercise Rights
☐ Cannot Manage Affairs

ACTIVITY NEEDS
☐ Not Participating
☐ Vision/Hearing
☐ Chair/Bedfast
☐ Dependence/4 ADL's

NOTES:

Form HCFA-524 (11-85)

SEE REVERSE

RECORD REVIEW

☐ Drug Regimen Review (See SOM Appendix N Part 1).
☐ Satisfactory ☐ Unsatisfactory

ROUTINE REPORTS: ☐ Weights ☐ Lab ☐ X-ray ☐ Other

ASSESSMENT	PLAN	INTERVENTION	EVALUATION

PHYSICIAN SERVICES

☐ Admission Information
☐ Rehabilitation Information
☐ Physical Exam
☐ Written Care Plan
☐ Signs Orders/Notes
☐ Required Visits
☐ Emergency Availability
☐ Review of Care

PROCEDURAL GUIDELINES

New Long Term Care (LTC) Survey Process

PROCEDURAL GUIDELINES

INTRODUCTION

The purpose for implementing a new LTC survey process is to better assess whether the quality of care, as intended by the rules and regulations, is actually being provided to Medicare/Medicaid residents in nursing homes. Although the onsite review procedures have been changed, facilities must continue to substantially meet all applicable Conditions/Standards in order to participate in Medicare/Medicaid programs. That is, the methods used to compile information about compliance with rules and regulations are changed; the rules and regulations themselves are not changed. The new process differs from the traditional process in its emphasis on resident outcome. In ascertaining whether residents' grooming and personal hygiene needs are met, for example, surveyors will no longer routinely evaluate a facility's written policies and procedures. Instead, surveyors will observe residents in order to make that determination. In addition, surveyors will confirm, through interviews with residents and conversations with staff, that such needs are indeed met on a regular basis. In most reviews then, surveyors will ascertain whether the facility is actually providing the required care and services rather than whether the facility is capable of providing the care and services.

ROLE OF SURVEYOR

The primary role of the surveyor is to assess the quality of care provided by a health care facility. In performing Medicare/Medicaid survey activities, the surveyor is charged with ensuring that the facility is in compliance with all the conditions of participation as set forth in the Federal Code of Federal Regulations. The surveyor's responsibility is to advise the facility management of deficiencies identified during the course of the survey and to ensure that appropriate action is taken to correct the deficiencies. As such, the survey process is properly characterized as an inspection and enforcement process.

Some questions have recently been posed as to whether the survey process also includes a surveyor consultation function. Among the surveyor's responsibilities both during and after the onsite visit is to identify the deficiencies in accordance with specific regulatory requirements in an effort to assist the provider or supplier in complying with deficient conditions. This identification and communication of the deficiency to the provider or supplier is referred to as "consultation" in the regulations (42 FR 405.1903(a)). However, this type of consultation does not include professional technical advice on how a specific deficiency might be corrected. It is HCFA's policy that facility operators who are in business to provide a certain type of health care, should be fully qualified to independently manage and operate their institutions in accordance with good business practice. If a facility needs the services of a professional consultant to advise them on business or health related matters, then they should undertake to hire one. Surveyors should not provide such consultation since budget allocations to the States for surveyor staffing resources do not include funding for consultative services. Also, the surveyor's role as inspector and enforcer may be compromised if the surveyor approves plans of correction that accommodate only the surveyor's suggested remedial action and do not necessarily address the real problem. While the facility operator might find it easier to simply adopt the surveyor's suggestions, there is no assurance that the surveyor has found the real root cause of the deficiency. For example, if a surveyor in a nursing home learns that residents are being served cold meals, it is not the surveyor's responsibility to determine the root cause (e.g., lack of aide training in food service, meals not properly cooked, food warmers broken, etc.). Rather, the surveyor should simply indicate that food is being served cold. The facility management should determine what caused the problem and submit a plan of correction to address it. The surveyor, on returning to the facility for a followup, should not look to see if the facility has taken the action indicated on the plan of correction, but should rather make a determination based on interview and observation that the food, in fact, is now being served at the proper temperature.

Finally, while surveyors should never function as consultants, and should not delve into the facility's policies and procedures to determine the root cause of a deficiency, surveyors should point out an obvious problem that has surfaced either during the survey itself or at the exit conference. For example, a surveyor should point out that he or she noticed that the temperature control on a food warmer device was set at an improper level.

SURVEY TEAM

Ideally, survey teams should consist of no less than two nor more than five members. However this may be impracticable because of fiscal and other constraints. The core surveyor for the process is the/a nurse surveyor who must be present on all surveys. The survey process can be apportioned according to either of two options. Option one is to use registered nurses as generalist surveyors handling virtually all aspects of the survey and utilizing discipline-specific surveyors as needed for consultation and/or onsite review for specific areas as identified by the nurses. The second option is to utilize a multidisciplinary team with each surveyor being assigned portions of the survey process according to expertise/discipline. For example, the/a nurse surveyor should complete the nursing services staffing chart as well as notifications and transfer indicators, since these can be gleaned from records reviewed in the in-depth sample. Simultaneously, the surveyor handling the physical environment requirements can review linen and housekeeping. The team members should be able to identify problems not specific to their area(s) and bring them to the attention of the appropriate surveyor.

OVERVIEW

A complete LTC facility survey essentially will consist of three components--Life Safety Code requirements; administrative and procedural requirements; and direct resident care requirements. The three components are summarized here. Detailed procedures for Part A and Part B are given in subsequent sections.

I. Life Safety Code (LSC) Survey

The LSC portion is not affected by the new survey process. The LSC surveyor will continue to apply the particular edition of the Code applicable to each facility, either in conjunction with or separate from the activities of the other surveyors.

II. Part A of the LTC Survey Process

This portion consists of a review of the organizational and procedural requirements from all of the applicable Conditions/Standard. Part A includes the following types of requirements for both SNFs and ICFs:

- written administrative and resident care policies
- by law and other documents that govern the organization of the facility
- written agreements with outside resources
- staff qualifications and written development programs
- committee meetings and reports
- disaster preparedness and other written plans

III. Part B of the LTC Survey Process

Part B includes the requirements from all of the applicable Conditions/Standards that are directly related to resident care. It focuses on the actual provision of care and services, as well as resident outcomes. Part B includes Dietetic services requirements, for example, that address the actual preparation and frequency of meals. The facility's written policy governing meal hours, on the other hand, is not reviewed in this portion of the LTC survey because this type of requirement--written residents care policy--is covered in Part A.

USE OF PART A -- INITIAL SURVEYS ONLY

Use Part A of the LTC Survey Report form for initial surveys only. In some places, notice that Part A is unlike the traditional LTC survey form. Instead of repeating the condition, standard, and element of the regulations, the form has a simple statement of the essential nature of the administrative and procedural requirements: duplicative, repetitive and vague language has been eliminated. When applying Part A requirements, ascertain in the same manner as in the traditional process whether the facility is in compliance. A HCFA determination of compliance, based on documented examination of the written policies and procedures and other pertinent documents during the initial survey, will establish the facility's compliance status with Part A requirements.

Effect of Part A on Resurveys of Participating Facilities

Part A will not be used for resurveys of participating long term care facilities. Those facilities will be determined to meet the administrative and procedural requirements based on their history of compliance. This does not preclude surveyors from citing deficiencies pertaining to administrative and procedural requirements when uncovered incidental to a Part B survey. To assure continued compliance with the administrative and procedural requirements, each LTC facility, at the time of recertification, will be required to complete an affidavit attesting that there have been no substantive changes that would affect compliance. The affidavit language is included on the form HCFA-1516, Request for Certification in the Medicare and/or Medicaid program. Each facility will also agree to notify the State agency (SA) immediately of any changes in its organization or management which may affect its compliance status.

In those instances where the SA receives information that there have been substantial changes in a facility's organization and management:

- The State agency will not initiate a new Part A survey, but will review the identified change to ensure compliance with regulations.
- The SA will determine, through the Part B survey, whether those changes have had an adverse effect on the quality of resident care.
- If the quality of care has been adversely affected the SA will:
    - Cite the deficiencies on the form HCFA-2567; and
    - if justified, apply the appropriate sanctions based on the Part B findings.

USE OF PART B

Use Part B of the LTC survey Report form for all types of SNF and ICF surveys--initial, recertification follow-up, etc. Thus, each SNF and ICF will receive a Part B survey no less often than annually.

The Seven Survey Tasks in the Part B process are:

Task 1. Entrance Conference
Task 2. In-depth, Integrated Tour with Selection of Targeted Residents
Task 3. Observation/Interview/Medical Record Review of Each Sampled Resident
Task 4. Drug Pass Observation
Task 5. Dining Area 7 Eating Assistance Observation
Task 6. Formulation of Deficiency Statement (if necessary)
Task 7. Exit conference

Task 1. Entrance Conference

The purpose of the entrance conference in the new process is the same as the traditional process. These activities should be performed at all entrance conferences:

1. The surveyors should introduce themselves to the facility staff present at the entrance conference.
2. The surveyor should explain the long-term care survey process as resident centered in focus, and furthermore explain the basic steps of the survey process.

3. The facility should be asked to complete page 2 of form HCFA-519 (Resident Census) as soon as possible so that the information will be available for surveyors during subsequent tasks.

4. The surveyor should ask the facility to post a sign(s) noting that State surveyors are in the facility performing a survey and that they are available to meet with residents. The signs should be placed in readily viewed areas (at least one on each floor) and should note the location of the surveyors. They may be hand-written with legible large printed letters.

5. If the facility has a resident council, the surveyors should make arrangements to meet with the president and officers of the Resident Council.

It is recommended that surveyors wear identifying information at all times during the survey.

Task 2. In-depth, Integrated Tour with Selection of Targeted Residents

Residents - The primary purpose of the tour is to focus on resident specific and resident-centered areas of care and treatment. This crucial step also includes an overall, facility-wide assessment of the types and patterns of care delivery present within a facility. The second purpose of the tour is to focus on physical environment issues. Thirdly, during the tour the surveyor(s) will identify a targeted sample of residents for in-depth review. For these tasks the surveyor(s) will need to utilize the "Tour Notes" worksheet, the "Residents Selected for In-Depth Review" worksheet, as well as the Survey Report Form (page two) entitled "Resident Census and Conditions of Residents".

It should be anticipated that an in-depth tour will require approximately 3 hours. A high quality home may require less time; a poor quality home may require more.

The tempo and depth of the tour should be determined by the surveyor(s) not the facility. The tour format should allow the surveyor(s) time to pursue leads. For example, should a soiled, bloodied, and malodorous dressing be found on a resident that is in obvious need of being changed, the surveyor would then want to focus extra attention on such areas as staff assistance, clinical techniques, and infection control, as well as seeking out other instances of similar problems.

The activities of touring include conversing with residents, family members/significant others (if present), and staff, as well as recording findings. Skilled interviewing techniques are required especially utilizing the method of asking open-ended questions and avoidance of yes/no questions. The purpose of the questions is to validate observations, obtain pertinent and substantial information, and to probe deeper with the investigation as needed. Confidentiality of information provided and privacy of the residents must be respected during this process, particularly on the areas of timing and technique of the data gathering process.

Section A -- The tour should focus on the resident's needs, and whether or not those are being met. These needs may be physical, emotional, social, psychological, or spiritual.

Each resident should be scanned for the following while touring:

--Personal Hygiene, Grooming, and Appropriate Dress
--Position
--Assistive Devices
--Ambulation
--Other restorative Devices
--Restraints
--Rehabilitation Issues
--Hydration and Nutritional Status
--Infection Control
--Resident Rights
--Activity for Time of Day (appropriate or inappropriate)
--Emotional Status
--Level of Orientation
--Awareness of Surroundings
--Behaviors
--Cleanliness of Immediate Environment (wheelchair, bed, bedside table, etc.)
--Odors
--Adequate Clothing and Care Supplies as well as Maintenance and Cleanliness of Same

Observe interactions between staff and residents as well as between staff members. These observations can provide insight into issues such as resident rights, staff's assignment of responsibilities, and meeting with Resident Council representatives, if appropriate.

In addition to scanning individual residents, the tour should focus on assessing the residents as a group, looking for overall patterns and trends of care. For example, the surveyor might note that three-quarters of the residents are wandering aimlessly, sit and look into space or otherwise appear bored, and verbalize to the surveyors that indeed this is the case.

As another example, surveyors may note at various times during the tour that several staff members do not protect residents' privacy. That is, staff do not knock on resident doors before entering rooms; staff members do not appropriately robe and cover a resident being transported to the shower room; staff change a resident's clothing with the room door open, etc. All of these incidents show a pattern or trend of disregard for resident's rights.

Pertinent findings about care and resident conditions should be noted with the resident's name or room number (Mrs. S. #1632) and this identifier is used by the surveyor on the "Tour Notes" worksheet. Unmet needs are a priority to be noted, and verified by resident and/or staff. Residents with unmet needs or potentially negative outcomes of care should also be considered for inclusion in the targeted sample for in-depth review and listed on the "Tour Notes" worksheet. For example, if 10 of 50 residents exhibit poor grooming and hygiene, this issue should be included in the representative sample of residents.

Section B -- The tour should encompass a review of physical environment.

This activity is integrated with the other aspects of the tour. Resident's room and auxiliary room that is observed should include a review in connection with physical environment requirements. It is not necessary to document physical environment on the Tour Notes Worksheet. Instead, surveyors may note these findings directly on the Survey Report Form.

Section C -- Selecting a targeted sample of residents during the tour.

Selecting a sample of residents using the concept of targeting means that residents are chosen to predetermined selection criteria. Calculate the sample size according to this guide:

> 59 beds or less - 5 residents
> 60 beds or more - 10% of the facility census with a maximum of 30 residents.
> (Use as facility size the total number of residents, including Medicaid, Medicare, private pay, VA, etc.)

The two selection criteria are as follows:

1. Residents chosen for the sample should be representative of the facility population as a whole, based on the following four categories:

   a. Alert with light care needs
   b. Confused with light care needs
   c. Alert with heavy care needs
   d. Confused with heavy care needs

   It is likely that at least 40% of the residents will be capable of providing interview data. The remainder would be composed of residents who are disoriented, inappropriate in response, or simply cannot communicate. Utilize page 2 of the Survey Report Form which describes the total population of residents within the facility by conditions, problems, and general care needs. By reviewing this Form, you can ensure choosing a representative sample of residents for in-depth review.

2. Within each of the four categories in 1. above, residents in the sample should represent a variety of care needs or potentially poor outcomes of care.

   The process of sample selection should be accomplished as a result of the tour of the facility. During the tour, the surveyor(s) will visit each unit of the facility meeting residents and staff, viewing rooms, etc. During the "scanning process" the surveyor(s) is able to briefly assess the resident and determine how criteria for selection apply. The surveyor(s) should also ask the facility for information about residents that may not be observable such as accidents, decubitus ulcers, special diets, a new admission, etc.

   In order to ensure a variety of care needs are met, selection of residents should also be based on the presence of potentially poor outcomes of care, particularly facility-wide patterns that may indicate poor care. Be alert to general pervasive signs of poor care and/or a lack of attention to resident needs. By selecting for in-depth review residents who seem to reflect a pattern of poor care, a surveyor(s) can validate his/her questions about this care. General patterns of poor care can be observed in a minimum of three areas: grooming and personal hygiene, social/emotional needs, and restorative nursing needs. Since these are more general observations, all surveyors should be able to note these problems and bring them to the attention of the surveyor(s) who will perform in-depth review.

   The examples below are included to provide guidance for identifying potentially poor resident outcomes (e.g., contractures, decubitus ulcers) as well as examples of special care needs (e.g., bedfast, vision impairments) in order to include them in the intensive review. Reviewers should not limit their sample resident selections to these criteria.

Potentially Poor Outcomes

Lack of cleanliness/poor grooming

Odors

Inappropriate dress

Urine puddles/wet linens

Foley catheter

Catheter bag on floor, unclean

Urine unclear/dark, bloody

Unresponsive/drowsiness

Withdrawal/depression

Poor skin integrity

Decubitus ulcer

Restraints

Contractures

Edema

Underweight/overweight/ emaciation/signs of malnutrition

Dehydration

Fractures/Accidents

Special Care Needs/Treatments

Ileostomy/colostomy/tracheostomy /nasogastric tube

Intravenous/Blood Infusion

Coma

Disorientation/aggressive/disruptive /inappropriate behavior

Incontinent

Need for assistance in ADLs (restorative nursing)

Bedfast/wheelchair bound

Rehabilitation services

Vision, hearing, speech impairments

Recent return from hospital or new admission to facility

Diabetes

Wounds/dressing

Isolated residents

Section D -- Tour Completion and Ongoing Tour Findings

When the formal tour is completed, the surveyor(s) should discuss problematic findings and refocus as necessary, as well as transcribe Tour Notes onto the Survey Report Form under the appropriate rule. (Note that the Survey Report Form is a multi-paged form containing the regulatory requirements on the left-hand side of the page with room for explanatory statements on the right.) Tour notes do not necessarily indicate the presence of a deficiency, however, they should be transferred over to the Survey Report Form because findings discovered at a later point in the survey or by another surveyor may combine to substantiate a deficiency.

When the tour is completed, the listing of residents chosen for in-depth review is transposed onto the worksheet labeled "Residents Selected for In-depth Review". If one surveyor has been delegated to identify residents for review, the worksheet can be filled out as appropriate. If several surveyors have shared responsibility for targeting residents, they should discuss the residents identified, their rationale for targeting, and then decide on a final sample for in-depth review.

During the remainder of the survey, the surveyor(s) should continue carrying "Tour Notes" worksheets inorder to note findings as appropriate. The surveyor(s) should not only focus on the targeted sample, but continue to observe all residents in the facility as well, noting whether their needs also are being met. Periodically throughout the survey these findings can be transposed onto the Survey Report Form under the appropriate rule.

Section E -- Meeting With Resident Council Representatives

If a facility has a resident council, surveyors should meet with its representatives. When meeting with this group, surveyors should introduce themselves and explain their disciplines as well as the purpose of the survey. They should also indicate that they are interested in learning about the strengths of the facility in addition to any complaints or shortcomings.

Surveyors can use this meeting to obtain information in three ways. As an open-ended discussion it can serve as a barometer, measuring what is important to residents and as a catch-all for any problems apparent to them about the facility. Or surveyors may have noticed possible problems during the current survey and want to gather more information. Finally, surveyors can ask residents to choose priority areas they feel need to be discussed.

The issues residents seem most concerned about probably fall into one of the following groups:

1. Cleanliness and Atmosphere in the Facility
2. Nursing and Medical Care
3. Personal Care
4. Attitudes, Treatment, Dignity
5. Rights and Choices
6. Food
7. Activities

The surveyor should approach a topic in a manner that allows for any kind of comment. Examples of open ended questions are:

1. What is best about the cleanliness of this home? What is worst? What would you like to change?

2. What do you like about the medical care in this home? What don't you like? What would you like to change?

Simple questions, to the point, that leave room for any kind of answer, are best. In order to get more detail, questions can be followed by: "Can you be more specific? Can you give me an example? Tell me what you mean. What can the rest of you tell me about this?" Surveyors should try to get a range of information, instead of going into so much depth, by a series of "What else?"

The key to the discussion process is that information and priorities come from the residents. Any prescription for questions to be asked and topics to be discussed could inhibit this vital element of the process. Surveyors should identify areas they wish to know more about and then lead discussions through those areas with questions like, "Tell me what you think about the food here. What would make it better? What would you like changed? What don't you like? What do you like?" Or surveyors can ask residents to identify areas about which they feel the greatest concern. Once again the leader would use the same open-ended questions to learn more about the residents' concerns.

The information obtained through the council can be used to assist in focusing other parts of the survey.

Task 3. Observation/Interview/Medical Record Review of Each Sampled Resident

After selecting residents for the sample, the surveyor evaluates specific indicators for each resident, utilizing the "Observation, Interview, Record Review (OIRR))" worksheet.

The purpose of the in-depth review of the targeted sample is to assess whether the facility meets the needs of residents. If the team finds that the facility meets the needs of residents in the targeted sample, the process of in-depth review stops. If, however, the facility does not meet the needs of the sample residents, or if an issue is not resolved based on the original sample, the surveyor(s) can expand the sample as needed, in order to resolve the specific issue in question.

For example, if two residents in the targeted sample of 10 are not receiving proper catheter care, it is necessary to examine care rendered to an additional sample of residents. However, the review of their care should be directed only at catheter care. Sampling should stop when the surveyor has decided that the catheter care is or is not proper.

Residents receiving improper catheter care should be reported to the facility. If a deficiency is cited, it will be in the provision of nursing services. Enlarging the sample will help to clarify whether the questionable situation is an exception or the routine. It will also support a determination of adverse action, if any, with solid documentation.

Observations should be performed concurrently with interviews of residents, family/significant others, and staff interviews. Findings from these two tasks will help to direct the surveyor during the medical record review.

The in-depth review should be performed in a nonthreatening, and noninvasive fashion so as to decrease anxiety and defensiveness. The open-ended approach described for use in meeting with the Resident Council (Task 2, Section E) is appropriate for the in-depth review as well. The resident's interview can be formal or informal depending on the tone or wishes of the resident. If a resident does not want to speak with the surveyor, honor the resident's wishes.

The length of interview will vary based upon the condition and wishes of the resident and the amount of data supplied by the resident. However, most interviews should last approximately 15 minutes. Interviews must be courteously terminated whenever a resident indicates inability or unwillingness to continue.

Some of the residents in the sample can not be interviewed as reliably or as in-depth as others due to mental/physical conditions. Others will not be able to communicate at all. For those residents, the surveyor should observe the resident for level of awareness and orientation, types of behaviors, etc., and reconcile with staff and medical record review to assess whether the facility meets the resident's needs.

The surveyor should exercise judgement in terms of what to document from the interview. All questions asked may not require the answers to be documented. However, documentation will depend upon the reason the surveyor needs to specifically recall the resident's response i.e., supporting data for a deficiency, etc. Documentation should be done on the OIRR worksheet itself so as to centralize data gathered.

The surveyor should observe and ask staff questions about the care and treatment rendered to residents as well as the technique and frequency. These observations and interview results can validate surveyor findings and contribute substantive information to the documentation of investigative findings.

Observation/interview areas focus on:

- Activities of Daily Living
- Grooming/Hygiene
- Nutrition/Dietary
- Restorative/Rehabilitation Care and Services
- Activities
- Social Service
- Resident Rights

In addition, other areas for review are selectively based upon the resident's needs, as observed by the surveyor. These include:

- Bowel and Bladder Training
- Catheter Care
- Restraints
- Injections
- Parenteral Fluids
- Tube Feeding/Gastrostomy
- Colostomy/Ilestomy
- Respiratory Therapy
- Tracheostomy Care
- Suctioning
- Other

When the resident and the staff have been observed and interviewed to the extent deemed necessary by the surveyor, the record review can commence. Rather than perform the interview and observations first, some surveyors prefer to initially perform the record review, complete resident/staff observations and interviews, and finally, return to the record for any final unresolved issues. Either method is acceptable and left to the judgement of the surveyor. What is important, however, is that the surveyor complete one resident's observation/interview/medical record review before moving onto another resident. By drawing conclusions and documenting those conclusions on the OIRR worksheet before moving onto another resident, the surveyor is less apt to lose important survey findings. Depending on staff and resident schedules, there will be instances when the surveyor will have most of the OIRR tasks completed except for isolated matters such as observing a special treatment or talking to a specific staff member. In that case, the surveyor will move onto another resident before completing the review of the prior resident.

The resident record review is a two-part process. First, surveyors must reconcile their observation/interview findings against the record to determine if a proper assessment has been performed, a plan has been developed with goals, interventions have been carried out, and the resident evaluated to determine the effectiveness of the interventions. This review process additionally aids the surveyor in ascertaining how care outcomes resulted, particularly negative outcomes. For example, if a resident has developed a decubitus while in the facility, the surveyor can utilize the record review to validate staff and resident interviews regarding the facility's attempts at prevention.

Secondly, the surveyor must reconcile the record against itself. This means that the surveyor should determine if the resident has been assessed for all his/her needs and that plans, interventions, and evaluations are properly carried out in concert with the needs identified in the assessment. Also, the surveyor evaluates the record to insure that normal and routine nursing practices such as periodic weights, temperatures, blood pressures, etc., are performed as required by the resident's conditions. Include in this record reconciliation a few closed records to ascertain whether transfers and discharges were properly documented. In summary, record review requires that surveyors identify documentation which satisfies them that the resident has had appropriate assessments, planning, interventions, and evaluations. However, facilities need not establish specific record areas stating "Assessment", "Plan", "Intervention", or "Evaluation" for any condition or problem.

Following each in-depth resident review the surveyor should briefly summarize on the OIRR worksheet the findings and resident conclusions from the review highlighting problematic areas on the OIRR which need to be transferred to the Survey Report Form. This summary allows the surveyor to make decisions regarding adequacy of care on a case-by-case basis. Summarizing will also aid the surveyor by ensuring that the essence of the issue is transferred cohesively to the Survey Report Form. Finally, summarizing will also cue the surveyor to thoroughly examine the other residents in the sample for the same types of problems. Once all the OIRR worksheets are completed, the surveyor can review each summary statement for the identification of patterns or trends. It is recommended that surveyors not transfer data from the OIRR worksheet to the Survey Report Form until all of the OIRR worksheets are completed and summarized.

Task # 4 Drug Pass Observation

The Drug Pass Observation allows the surveyor to observe the actual provision of medications to residents. For this process, the surveyor will use the "Drug Pass" worksheet. The drug pass observation methodology eliminates the necessity of evaluating nurses notes or medication administration records for probable drug administration errors. In this manner, findings from the drug pass observation are definitive and cannot be presented or excused as merely documentation errors.

The drug pass observation should be conducted by only one surveyor. The observation should be conducted for approximately 20 residents. While residents selected for the in-depth review may be included within those 20 residents, for reasons of efficiency this is not intended, nor is it required. Staff observed and drug pass times chosen are left to the discretion of the surveyor. Please refer to the State Operations Manual Appendix N, Part II (Rev. 174-3/85) for specific information on how to conduct and evaluate this portion of the survey.

Findings noted on the "Drug Pass" worksheet are transferred onto the Survey Report Form under the appropriate rule.

Task 5 Dining Area and Eating Assistance Observation

Because mealtimes are focused events during which the care of many residents can be observed, surveyors should observe how well the facility meets the resident needs, particularly those requiring eating assistance. This eliminates the inherent difficulty in identifying and observing only sampled residents. Additionally, the efficiency of this method allows surveyors to observe a significant number of residents in a concentrated period of time and again allows for the identification of trends/patterns. Be sure to observe other residents who have their meals in their rooms as opposed to the dining areas only.

For this task the surveyor will use the worksheet entitled "Dining Area and Eating Assistance Observation". One task asked of the surveyor on the worksheet is to select a minimum of five residents to compare meals served with the diet card and physician orders. Surveyors should expand their sample if there are questions about diet and/or diet ordersfor any resident in the initial sample. The review of care should encompass only the specific are(s) in question. Sampling should stop when the surveyor has decided that care is or is not proper.

Residents receiving improper care should be reported to the facility. If a deficiency is cited, it will be under the requirements for therapeutic diets. Enlarging the sample willhelp to clarify whether the questionable situation is an exception or the routine. It will also support a determination of adverse action, if any, with solid documentation.

It is recommended that the surveyor(s) observe two meals and use one worksheet for each meal, unless the surveyor(s) clearly indicates that one worksheet is for more than one meal observation. Surveyors may use their own discretion as to which meal to observe.

Surveyors should give particular care to performing observations in as nonobtrusive fashion as is feasible. Chatting with residents and sitting down nearby may help alleviate resident anxiety over the observation process.

The dining observation also provides surveyors with information on a wide range of nondietary issues. These include such items as staff interaction with residents, prompt and appropriate assistance, adaptive equipment usage and availability, as well as dress and hygiene appropriate for meals.

The facility will be evaluated for how well it assesses, plans, and evaluates the nutritional care of residents and eating assistance needs when the surveyor reviews the care of residents selected for in-depth review.

As with the other survey tasks, findings noted on the "Dining & Eating Assistance Observation" worksheet are to be transferred onto the Survey Report Form.

Task 6 Formulation of Deficiency Statement

The Survey Report Form will ultimately contain information about all the findings of the surveyor(s). Therefore, it is important that all data from the tour, drug pass observation, dining area & eating assistance observation, as well as in-depth review of the targeted sample of residents be transferred.

The survey process will flow more smoothly if the surveyor(s) summarizes issues (to the extent feasible) at the completion of each survey task. For example, at the end of tour and after reviewing tour notes, the surveyor(s) may indicate that overall the residents were clean and well groomed, with restorative needs being met; however, resident rights problems were identified as well as lack of appropriate activities for all residents. By summarizing problematic areas at the completion of each survey task, the surveyor can also identify clearly which areas will need added focus in order to fully document and substantiate the deficiency.

The findings on the Survey Report Form then need to be analyzed for the following:

1. Survey findings need to be evaluated as to their severity. A finding directly related to the health, safety, and welfare of a resident(s) may be an isolated occurrence. However, because it is threatening the resident's emotional or physical well-being, that finding alone may warrant the issuance of a deficiency. For example, the surveyor may discover that a resident experienced a change in physical condition that was not acted upon in a timely or appropriate fashion by the facility. Because of this lack of response by the facility, complications developed that threatened the resident's physical and emotional well-being. Even though this may be an isolated instance, the severity of the issue and the effect upon the resident's well-being may warrant issuance of a deficiency.

2. Survey findings must be evaluated in terms of frequency of occurrence and/or the presence of patterns. For example, surveyors may discover that 2 of 10 residents in the sample display upper and lower extremity contractures that are assessed and have current plans for appropriate intervention; however, that intervention is not occurring. Surveyors should expand their sample of residents who have contractures to determine if a pattern of non-intervention occurs before using this finding to support a deficiency. Surveyors should only expand the sample until they are satisfied that care is or is not proper. Surveyors should examine only the specific need inquestion. Whether or not a deficiency is cited, surveyors should always report to the facility the names of residents receiving improper care. The number of problems observed in order to formulate a pattern or trend may vary from deficiency to deficiency. Two out of 10 may be sufficient to establish a pattern. On the other hand, the surveyor may have discussed the situation with facility officials and concluded that lack of intervention was warranted under the particular circumstances.

3. The surveyors must ensure that the explanatory statements on the Survey Report Form reflect the findings of the survey for each broad area reviewed e.g., Nursing Service, Dietary, etc. For example, the findings on worksheets indicate that the food service delivery is disorganized, resulting in cold food being served. Does the documentation transposed onto the explanatory statements on the Survey Report Form reflect that? Has all data been transcribed, i.e., food temperatures with the time and date? Are there any comments from residents or staff to transcribe for substantiation?, etc.

   Combinations of problems in care such as poor grooming of a number of residents, lack of ambulation of a number of residents, lack of attention to positioning, poor skin care, etc., should yield a deficiency in nursing services just as 10 out of 10 residents receiving poor care for decubiti would yield a deficiency. Additionally, surveyors should be alert to certain other indicators which would follow from this deficiency in the provision of care itself. For example, a deficiency for insufficient staff should result if surveyors note care problems and also note that available staff are excessively busy but, in spite of their efforts, are unable to meet the needs of the mix of residents. At the same time, a deficiency for supervision should result if surveyors note lack of care and aides sitting around the nursing area generally unoccupied throughout the duration of the survey. Finally, a deficiency for training should result if care is being provided inappropriately, or if facility staff indicate training courses specified the observed inappropriate procedures or were not provided by the facility.

4. Finally, for each broad area reviewed, the surveyors must decide if the findings are of sufficient severity, frequency, and well enough substantiated to warrant the issuance of a deficiency. If so, the surveyor must decide as in the traditional survey process, whether the deficiency is at the level of element, standard, or condition.

When this analysis of the data is complete, the surveyor can proceed with writing a deficiency statement.

As in the traditional process, complete the Deficiency Statement and Plan of Correction, (HCFA-2567). While the names of residents should not be indicated, it is important to be specific in the documentation. Sample items from a deficiency statement follow. Note the format - regulatory citation, followed by a summary of the deficiency, and supporting findings. Include the data prefix tag, if available.

Deficiency Statement

1. SNF 405.1121(k)(9) -- Each resident is not treated with consideration, respect, and dignity, and the resident's right to privacy during treatment was not always provided for as evidenced by the following.

On 10/23 at 10:00 a.m. the nurse was observed applying a wound dressing to Resident #1620's inner thigh while the resident sat in her wheelchair in her room with the door open and no screening used.

On 10/23 at 9:30 a.m. staff members were observed entering Resident #1611's room without knocking on the door prior to entering. They gave no reason for being in the room and did not close the door when they left.

On 10/23 at 10:30 a.m. staff were observed entering Resident #1613's room without knocking prior to entering. A.M. cares were given with no privacy screening used.

On 10/23 at 12:00 Noon a staff member standing and feeding resident #1625 was overheard to say "hurry up, hurry up".

2. SNF 405.1123(b)(6) -- Each resident has not had a physician's visit at least once every 30 days. Resident #1602 has not been seen by a physician in the last 50 days. Her condition has deteriorated since that time (formulation of decubiti, infections).

3. SNF 405.1124(c)1,2,3,4,5,6,7,8,9 -- The facility did not provide 24 hour nursing services to meet total nursing needs as evidenced by the following examples in the areas of grooming, appropriate dress, infection control, and proper care to prevent deformities, decubiti, and improper medication administration.

On 10/23 at 11:00 a.m., Resident #1641 was noted to be up in the lounge in his wheelchair dressed in his own clothes and slippers, but wore no socks.

On 10/23 at 10:45 p.m., Resident #1629 was noted to be up in a geri-chair in the activity room, dressed only in a gown and socks with her legs only partially covered by a lap robe. No shoes, nor robe.

Residents #1602 has Stage III and Stage IV decubitus ulcers on the outer aspect of her left ankle and dorsum of foot (1" x 1" and 1.5" x 1"). This resident has unmet needs resulting in skin breakdown, nutritional problems, poor personal care, and infection. Resident's hair oily and uncombed. Lips dry and cracked. Skin reddended on elbows and between knees, open area on left hip (pea sized). These were not assessed or acted upon by nursing staff. Found in bed with head of bed rolled up. Resident slid down to foot of bed. No footboard. No pillows for positioning. Urine smell in room. Purulent and odorous drainage from foot decubiti and sacral decubitus (2 1/2 cm. xx 3 1/2 cm deep). No wound cultures done. On 10/24 RN noted to not wash hands before or after decubitus care. Laid the soiled dressing on overbed table next to sterile dressing and later disposed of the used dressing in the wastebasket in the resident's bathroom.

Resident #1609 on 10/23 at 10:00 a.m. was observed with unkempt hair, bath blanket for lap robe.

READEX FICHE

Resident #1613 restrained in geri-chair for two hours without release on 10/23. At end of two hours, resident had episode of urinary incontinence.

Resident #1621 noted on 10/23 to have assistive device for dressing which was broken 10 days ago. Reported to staff, but no word from staff as to when it will be repaired.

Resident #1606 being ambulated by one nursing assistant on 10/23 in hallway wearing socks, but no shoes.

Resident #1611 on 10/24 was noted dressed in a faded dress with spots of dried food noted on it, sweater buttoned unevenly, not wearing stockings, bra, or slip. Undershirt showing at neckline. Facial hair evident. Dirty untrimmed fingernails. Skin flaky, dry lips. Sores on arms, stress incontinence, and leg bruises.

Task 7. Exit Conference

The purpose of the exit conference is to inform the facility of survey findings. That is, before formally citing deficiencies, discuss any allegations or findings that, for a variety of reasons, couldn't be substantiated in earlier tasks in the process. For example, if information is gathered that suggests a newly hired R.N. is not currently licensed, ask the facility officials to present current licensure information for the particular nurse in question.

The tone of the exit conference will be consistent with the character of the survey process--inspection and enforcement. Tactful, business-like, professional presentation of the findings and determination of compliance or non compliance with the regulatory requirements is of paramount importance. Although deficiency statements continue to depend on surveyor professional judgement, this process provides for resident-specific examples that are indicative of a breakdown in a facility's care delivery system. Refer to the earlier section on "Role of the Surveyor" for discussion of the limited function of consultation.

PLAN OF CORRECTION

Because surveyors are inspectors and enforcers, they are charged with the identification of care and services not consistent with the regulatory requirements rather than ascertaining the causes of the deficiencies. Thus, each facility is expected to review its own care delivery system to locate the root causes for inadequate care. Following the exit conference, each facility is required to submit a plan of correction that identifies necessary changes in operation that are believed to assure correction of the cited deficiencies. Plans of correction specific to residents identified as examples of improper or inadequate care are not acceptable. Rather, the plan should address the system level problems that may have resulted in the negative care outcomes - the deficiencies. It is incumbent on the facility not only to show intent to correct the deficiency, but describe or demonstrate how it will correct the deficiency.

PAPER FLOW

Once the survey is completed and the exit interview accomplished, the State survey agency retains the various survey worksheets as well as the Survey Report Form. The deficiency statement is forwarded to the HCFA regional office as per usual procedures.

FOLLOW-UP

Follow-up surveys differ somewhat from those conducted under the traditional process. While surveyors continue to ascertain the corrective status of all cited deficiencies on the HCFA-2567, surveyors focus again on the situation with an outcome oriented perspective. That is, surveyors will re-evaluate the specific types of care provided to residents that were identified as deficient. If care problems continue to exist, the surveyor must assume that the facility's appraisal of its service delivery breakdown or the implementation of its plan for correction was insufficient. At this point, further action on the certification status of a facility which remains non-complaint will follow traditional procedures. Surveyors should refer to the appropriate section of the SOM.

FORMS UTILIZATION GUIDES

The forms utilized in the Federal method of survey were developed to be utilized in an inter-related fashion. The Survey Report Form shall be used for both skilled nursing facilities and intermediate care facilities. In dually certified facilities the skilled nursing regulations apply except when there is a question of care about a resident classified at the intermediate care level.

In skilled nursing facilities with an intermediate care distinct part, the SNF and ICF regulations apply.

The Federal Survey Packet Contents

Form	Number
Tour Notes	One (1) or more per surveyor
Residents Selected For In-depth Review	One (1) per surveyor and one for completed packet, dependent on sample size
Drug Pass Worksheet	Two (2) or more
Dining Area & Eating Assistance	One (1) per meal to be observed
Observation/Interview/ Record Review	One (1) per resident in sample
Survey Report Form (Includes Face Sheet - patient census)	One (1)
Deficiency Statements (Form #2567)	As needed

Usage of the Form

Form	Instructions
Face Sheet	-- Complete all areas with the assistance of the facility.
	-- Submit with complete survey packet.
Resident Census	-- Each total within the blocks of descriptive information regarding residents is to equal 100% of the resident census, except the block in the lower right hand corner of the second page.
	-- Submit with complete survey packet.
Tour Notes	-- Utilized by all surveyors in facility to maintain notes regarding resident findings at any time while in the facility. Physicial Environment findings need not be noted on this form. They may be documented directly on the Survey Report Form.
	-- Each surveyor transfers problems found to Survey Report Form under appropriate rule in column labeled "Explanatory Statements".
	-- Maintain in State office.
Residents Selected for In-Depth Review	-- Completed by surveyor(s) selecting sampled residents for in-depth review. Fill out name or identifier of resident and reason for selection.
	-- Maintain in State office.
Drug Pass Worksheet	-- Completed by surveyor while observing the drug pass observation.
	-- Findings transferred to survey report form under appropriate rule in column labeled "Explanatory Statements".
	-- Maintain in State office.
Dining Area & Eating Assistance	-- One form completed for each meal observed.
	-- Review each indicator listed. Note findings on right hand side of page.
	-- Transfer problematic findings to survey report form under appropriate rule in column labeled "Explanatory Statements".
	-- Maintain in State office.

Observation/Interview/ Record Review	-- Complete one for each resident identified for in-depth review. -- Complete the observation/interview section while observing and interviewing the resident. -- Under ADL Section, check box if assistance is needed. -- For the remaining sections, check if condition or problem exists. -- The record review portion is completed separately from the interview/observation time. Complete as the surveyor reconciles observation/interview findings with the record and the record against itself. -- Complete the observation/interview/record review on a resident-by-resident basis, drawing together a summary of problematic findings or conclusions, and noting that summary in the "Notes" section. -- Transfer negative findings and conclusions to survey report form under appropriate rule in column labeled "Explanatory Statements". All information regarding each resident need not be transferred. Instead the note may read "See OIRR for resident # ___ re: poor catheter care." -- Maintain in State office.
Survey Report Form	-- Completed as surveyor(s) transfer problems from the following forms: - Tour Notes - Drug Pass Worksheet - Dining Area & Eating Assistance - Observation/Interview/Record Review Once data from all forms has been transferred, the surveyor(s) determines deficiencies as appropriate, indicating by marking the yes (met) or no (not met) or N/A, where the issue is not applicable. Rules indicated as not met are to be on HCFA 2567. -- Maintain in State office.
Deficiency Statements	-- Complete utilizing data gathered during survey and from survey report form.

CONSULTATION POLICY

INSPECTION AND ENFORCEMENT VERSUS CONSULTATION

The primary role of the surveyor is to assess the quality of care provided by a health care facility. In performing Medicare/Medicaid survey activities, the surveyor is charged with ensuring that the facility is in compliance with all the conditions of participation as set forth in the Federal *Code of Federal Regulations*. The surveyor's responsibility is to advise the facility management of deficiencies identified during the course of the survey and to ensure that appropriate action is taken to correct the deficiencies. As such, the survey process is properly characterized as an *inspection and enforcement* process.

Some questions have recently been posed as to the survey process also including a surveyor *consultation* function. Among the surveyor's responsibilities both during and after the onsite visit is to identify the deficiencies in accordance with specific regulatory requirements in an effort to assist the provider or supplier in complying with deficient conditions. This identification and communication of the deficiency to the provider or supplier is referred to as "consultation" in the regulations (42 FR 405.1903(a)). However, this type of consultation does not include professional technical advice on how a specific deficiency might be corrected. It is HCFA's policy that facility operators who are in business to provide a certain type of health care, should be fully qualified to independently manage and operate their institutions in accordance with good business practice. If a facility needs the services of a professional consultant to advise them on business or health related matters, then they should undertake to hire one. Surveyors should not provide such consultation since budget allocations to the States for surveyor staffing resources do *not* include funding for consultative services. Also, the surveyor's role as inspector and enforcer may be compromised if the surveyor approves plans of correction that accommodate only the surveyor's suggested remedial action and do not necessarily address the real problem. While the facility operator might find it easier to simply adopt the surveyor's suggestions, there is no assurance that the surveyor has found the real root cause of the deficiency. For example, if a surveyor in a nursing home learns that residents are being served cold meals, it is not the surveyor's responsibility to determine the root cause (e.g., lack of aide training in food service, meals not properly cooked, food warmers broken, etc.). Rather, the surveyor should simply indicate that food is being served cold. The facility management should determine what caused the problem and submit a plan of correction to address it. The surveyor, on returning to the facility for a followup, should not look to see if the facility has taken the action indicated on the plan of correction, but should rather make a determination based on interview and observation that the food, in fact, is now being served at the proper temperature.

Finally, while surveyors should never function as consultants, and should not delve into the facility's policies and procedures to determine the root cause of a deficiency, surveyors should point out an obvious problem that has surfaced either during the survey itself or at the exit conference. For example, a surveyor should point out that he or she noticed that the temperature control on a food warmer device was set at an improper level.

CARE GUIDELINES

CARE GUIDELINES FOR TOUR

These guidelines are intended to be used by the surveyor to aid in the application of consistent criteria in evaluating the facility during the tour portion of the Federal Long Term Care Survey. It is not intended as an inclusive listing of all items a surveyor should investigate, but rather as an aid to the surveyor in learning to apply the new survey instrument.

Assessing Overall Patterns and Trends of Care, Resident Centered

OBSERVATION AND INTERVIEW

1. Resident Rights

It should be evident that residents are able to exercise their rights as a patient and as a citizen. They should be able to speak with the surveyor as they choose. They should indicate that they are able to participate in their plan of care, can recommend changes in policies and services, can freely and without reprisal belong to Resident Council, etc. Residents should verbalize that they can manage their financial affairs, if able, and if not, are given a quarterly statement of their account. Staff should recognize resident rights by knocking on resident room and bathroom doors, etc. before entering, provide privacy during treatments, etc. Residents should be free from mental and physical abuse, and staff should treat them in a kind and considerate fashion. Chemical and physical restraints should be used only as a last resort (when necessary) to protect the resident. Residents who appear to be chemically restrained, over medicated, or unnecessarily restrained with physical devices warrant further investigation. Residents should not be required to perform work/service for the facility unless it is included as a therapeutic part of the plan of care. Residents should be able to send and receive mail unopened (unless medically contraindicated). Residents should have personal clothing and possessions as space permits, as they desire, and wear their own clothes. Married residents should be able to share rooms and have the privacy they need. Spouses of residents should be able to have private times with mates as they wish.

Related Regulations: Resident Rights: SNF 405.1121(k)
ICF 442.311

OBSERVATION AND INTERVIEW

2. Nursing Services

The facility should provide nursing services which are sufficient to meet the nursing needs of all residents, all hours of each day. Each resident should be clean and well groomed, and be dressed appropriately to time of day (i.e., street clothes unless acutely ill or per desire of resident). Diet and medication should be given as prescribed. Care should be given to prevent skin breakdown in individuals identified as high risk for decubitus ulcers. If a decubitus is present, care given should be appropriate to promote healing and control infection. Restraints are applied properly and are of appropriate material. Observe to verify that restraints are released every two hours for joint motion, exercise, toileting, etc. Incontinent residents are toileted as necessary to encourage continence, maintain self esteem, as well as maintain skin integrity. Episodes of incontinence should be taken care of promptly. Rehabilitation efforts in toileting appropriate residents should be evident. Urinary catheters, colostomies, and other devices utilized in promoting body elimination should show evidence of being cared for properly. Each resident should have all special needs and cares performed appropriately. The nursing staff should provide care in accordance with professionally accepted standards with emphasis on infection control.

Restorative and rehabilitation needs of residents should be identified and met on a daily basis. Hand rolls, splints, supports, foot boards, water mattresses, air mattresses, etc. should be used as needed. Residents should not be in bed 24-hours per day unless medically indicated or per resident rights.

Each resident should evidence appropriate rehabilitation and restorative care which promotes maximum physical functioning and prevents immobility, deformities, and contractures. If these conditions are present, there should be evidence of appropriate treatment. Investigation of the cause is warranted (i.e., failure of facility to provide proper preventive intervention). Range of motion (ROM), ambulation, and turning of residents should be evident on a routine and appropriate basis. Residents in need of such programs as reality orientation or remotivation show evidence of staff intervening appropriately on a one-to-one basis as well as with groups.

The nursing staff should display an awareness of each resident's nutritional status and needs as well as the appropriate intervention. This includes the provision and monitoring of fluids as needed. Deviations from normal are acted upon appropriately. Between meal snacks and nourishments are offered to residents who are underweight, emaciated in appearance, or who have impaired or threatened skin integrity. These nourishments are monitored and evaluated routinely. Residents who can benefit from self-help devices are identified. Staff displays an understanding of these devices as well as an ability to assist residents in appropriate usage. (See also Care Guidelines for Observation of Dining and Eating Assistance, pages 1-4.)

Nursing staff should display the ability to meet resident's needs in a timely fashion (i.e., response to call bells, resident requests, routine treatments and care, etc.). Changes in condition of residents should be acted upon appropriately and timely. Nursing staff should demonstrate the ability to provide care without unduly hurrying residents and allow residents to perform as much care as possible for themselves. Staff should appear busy, but not harassed. The presence of 24-hour per day staff should be apparent.

Staff should be performing duties consistent with their education and experience and based upon the characteristics of the resident load. For example, if nursing assistants are managing open wounds this should be observed and investigated for appropriate technique as well as training. Staff displaying an inability to perform any of their assigned duties warrants further investigation. While touring, observing, and speaking to staff, also look for evidence of weekly staffing schedules which are appropriately maintained, especially check for evidence of relief personnel. Each tour of duty should have a designated charge nurse. The charge nurse should display adequate and appropriate knowledge of the residents and their needs, be aware of and in control of assigned staff, and be able to perform and complete duties in a timely fashion.

Related Regulations:	Nursing Service	SNF	405.1124(b)
		SNF	405.1124(c)
		SNF	405.1121(e)
		SNF	405.1121(a)
		SNF	405.1124(f)
		ICF	442.338
		ICF	442.342

OBSERVATION AND INTERVIEW

3. Social Services and Activities

It should be evident that the social, emotional, and activity needs of residents are being met on an ongoing basis.

Residents should be involved in appropriate activities for the time of day, within individual physical limitations, as well as individual preference. Residents not involved or inappropriately involved should be interviewed during the tour to obtain their opinions and feelings about the offered activities. Activities going on in the facility should be displaying sensitivity to the residents physical, social, and mental well being as well as promoting opportunities for engaging in pursuits related to an individual's preadmission activity pattern.

The facility staff should display evidence of being able to meet the social/emotional needs of residents. Residents in need of acute intervention should be appropriately managed (i.e., a tearful resident is identified and comforted appropriately). Residents displaying inappropriate behaviors or abusive/disruptive behaviors should be observed for staff's ability to manage the behavior while protecting the rights of the involved residents as well as the rights of the other residents in the facility. If staff are unable to meet the needs of inappropriate/abusive/ disruptive residents, the surveyor is directed to further investigate the issue.

The facility should display evidence of appropriate placement of residents as well as timely discharge.

Dying or terminally ill residents should show evidence that their emotional and social needs are being met via staff time devoted to sitting with the resident, talking with the resident, counseling, etc. The facility should display a flexible attitude towards the family visiting hours, reasonable accommodations for same, privacy afforded, etc.

Related Regulations:	Social Services:	SNF	405.1130(a)
		ICF	442.344
	Activities:	SNF	405.1131(b)
		ICF	442.345

Physical Environment

OBSERVATION AND INTERVIEW

1. Nursing Units and Resident Care Supplies

Tour each nursing unit to determine that it is adequate in size and space, has sufficient storage areas, as well as sufficient supplies needed to provide the necessary care and treatment. Each unit should be clean and should have the following basic service areas: nurses' station, storage and preparation area for drugs and biologicals, and utility storage rooms with clearly defined "clean/dirty" areas that are adequate in size, conveniently located, and well lighted to facilitate staff functioning. Handwashing facilities with clean hand towels must also be available. The nurses' station is equipped to register calls through a communication system from resident areas, including resident rooms and toilet and bathing facilities.

Related Regulations:	Nursing Services	SNF 405.1124(g)(i)(c)
	Physical Environment	SNF 405.1134(d)
	Infection Control	SNF 405.1135
	Governing Body	SNF 405.1121(h)
		ICF 442.325

OBSERVATION AND INTERVIEW

2. Resident Rooms

Surveyors should observe resident rooms in order to determine whether the room is clean, orderly, and equipped for the provision of adequate nursing care. Look closely at furniture for maintenance, cleanliness, and safety. Check for adequate operation of the bed, lights, and handwashing facilities. Check for individualized closet and drawer space to accommodate personal clothing and possessions. With the resident's consent, open and inspect bedside cabinets and tables to assure cleanliness, proper labeling, etc., and to check for the presence of drugs, poisons, hazardous substances, or signs of pest/insect problems. Check for proper operation of the call system in several different rooms and also at the nurses' station. Verify that the call lights and/or buzzers function in the resident's room, and at the nurses' station and that call cords are easily accessible to residents.

Related Regulations:	Physical Environment	SNF	405.1134(e)
		ICF	442.325

OBSERVATION AND INTERVIEW

3. Resident Toilet and Bathing/Shower Areas

Based on the number of residents, there is an adequate number of toilets, baths, and showers in the facility which are éBBëaccessible to and functional for handicapped residents. These facilities are conveniently located in or near resident rooms. They are maintained in a clean, sanitary condition, and free from odors. Bathrooms are equipped with soap, toilet tissue, towels, etc. Hot water is between 105° and 115° or the acceptable State level. Hot water temperature control should be maintained. Conveniently located and secure grab bars and other safeguards are installed in toilet and bathing areas. Plumbing fixtures and surfaces of toilets, tubs, and basins are in good condition. The temperature in the room should be sufficient to enable residents to shower comfortably. The lighting and ventilation systems operate properly. Each area is equipped with a nurses' call signal and assures patient privacy.

Related Regulations:	Physical Environment	SNF 405.1134(d)(e)(j)
	Infection Control	SNF 405.1135
		ICF 442.326

OBSERVATION AND INTERVIEW

4. Activities and Dining Area

Adequate dining and activity space is provided to meet the needs of the resident. The area is large enough to accommodate all residents desiring participation. It should also be pleasant and conducive to relaxation. The facility provides one or more clean, orderly, and appropriately furnished room for resident dining and resident activities. Tables, chairs, tray stands, etc. are clean, sturdy, and well maintained. Tables accommodate wheelchairs comfortably. Lighting is at adequate levels without undue brightness or glare.

If the facility uses a multipurpose room for dining, diversional, and social activities, there is sufficient space to accommodate all activities without interference with each other.

Related Regulations:	Dietetic Services	SNF 405.1125
	Patient Activities	SNF 405.1131
	Physical Environment	SNF 405.1134(g)
		ICF 442.329

OBSERVATION AND INTERVIEW

5. Social Service Area

There should be an adequate amount of space and an appropriate area in which social service personnel can interview and speak privately with residents. Additionally the facility should have available adequate space for clerical functions.

Related Regulations: Social Service Area SNF 405.1130(b)
SNF 442.344(c)

OBSERVATION AND INTERVIEW

6. Therapy Areas

The therapy areas have sufficient space for therapeutic treatments. The equipment is clean, appropriate, and in good working condition. Verify that there is supervision provided for residents while receiving treatments.

Related Regulations: Specialized Rehab. Svcs. SNF 405.1126(a)
SNF 442.328(b)

OBSERVATION AND INTERVIEW

7. Common Resident Areas

All common resident areas are clean, sanitary, and free of odors. There is adequate and comfortable lighting levels. Distracting sounds are limited, and the room temperature is comfortable. Adequate ventilation whether through windows or mechanical means, or a combination of both, is present. Corridors are equipped with firmly secured handrails on each side. It should be evident in the design and structure of the common resident areas that the facility is taking into account the age and physical/emotional needs of the residents. Activity schedules are posted and readable, again, taking into account the age and physical needs of the resident population.

Related Regulations: Common Resident Areas SNF 405.1134(j)
SNF 442.324

OBSERVATION AND INTERVIEW

8. Dietetic Environment

The facility has kitchen and dietetic service areas adequate to meet the food service needs. These areas are properly ventilated, arranged, and equipped for sanitary refrigeration, storage, and preparation of food. Equipment and storage areas are clean, well maintained, within proper temperatures ranges, and safe.

Proper temperatures: (Fahrenheit)
Frozen food storage -- 0 or below
Cold food storage -- 40-45 degrees
Hot food holding equipment -- 140 degrees minimum
Dishwasher wash cycle -- 150-160 degrees
Dishwasher rinse cycle -- 180 degrees

Dietary personnel are clean and free of infectious disease. They practice acceptable techniques and procedures to keep foods at proper temperatures and protected against contamination.

Related Regulations:	Dietetic Services	SNF 405.1125(e)(f)(g)
	Physical Environment	SNF 405.1134(h)
	Infection Control	SNF 405.1135(b)(e)
	Governing Body	SNF 405.1121(h)
		SNF 442.331(b)

OBSERVATION AND INTERVIEW

9. Provision of Emergency Power

The facility contains on its premise an emergency source of electrical power to protect the health and safety of residents in the event the normal electrical supply is interrupted. It is adequate to supply power for lighting in all means of egress; equipment to maintain fire detection, alarms, and extinguishing systems; and life safety support systems. The surveyor verifies that the system is functional as well as routinely checked by the facility.

Related Regulations:	Emergency Power	SNF 405.1134.(b)

OBSERVATION AND INTERVIEW

10. Maintenance of Equipment, Building, and Grounds

Observe both the interior and exterior of the building to ascertain that the building is clean, orderly, and attractive.

- o Grounds are free of litter and debris.
- o Grass is cut in season; snow is removed from designated paths.
- o Grounds are accessible to all residents including those who are handicapped.

Check resident care equipment to ensure that it is maintained in a safe and operable manner. Plumbing, heating, and other essential equipment is functioning properly. The facility maintains adequate and comfortable lighting, temperature, and sound levels that are in accordance with established standards.

Related Regulations:	Physical Environment	SNF 405.1134(i)(j)
	Infection Control	SNF 405.1135(c)(e)
	Governing Body -	SNF 405.1121(h)
	Staff Development	SNF 442.324

OBSERVATION AND INTERVIEW

11. Infection Control

Observe all areas of the facility for cleanliness, potential safety hazards, unnecessary odors, etc. There is an adequate supply of cleaning materials for the size and type of facility. The materials and supplies used are recognized and accepted for institutional use.

The facility has available, at all times, a quantity of linen necessary for the proper care and comfort of patients. Clean linen and clothing are stored in clean, dry, and dust free areas. Areas in which the sorting of soiled linen, laundering, and extraction is performed are separated from the areas in which ironing, folding, and storage of clean linen occur. Soiled linen and clothing are placed in suitable bags or containers and stored in well ventilated areas, which are separated from clean linen. Soiled linen is not permitted to accumulate in the facility.

Surveyors verify that accepted infection control practices are being followed in the provision of individual resident care. Surveyor observation focuses on determining whether sufficient housekeeping personnel, equipment, and supplies are available to maintain a clean, sanitary environment. Specific items to be observed include:

- Soap and towels are available.
- Clean glasses and pitcher are provided.
- Tub, shower, and whirlpool are cleaned with appropriate frequency (i.e., between residents).
- Proper linen handling practices are used.

Assess the effectiveness of the facility's pest control program during the tour, paying special attention to the food storage areas, refuse containers, resident areas, and entrances.

Verify that the facility has provisions for isolating residents with infectious diseases in single rooms ventilated to the outside, with a private toilet and handwashing facility. Contaminated laundry is kept in clearly marked bags and handled separately. If nondisposable dishes and flatware are used to serve residents in isolation, they are kept clearly marked and handled separately.

Determine the written procedures in aseptic and isolation techniques are followed by all personnel (e.g., bladder irrigation, tube feedings, enemas, etc.). Arrange to observe some of these procedures (e.g., observe assistance with handwashing prior to dining, observe infection control techniques used in provision of treatments, observe methods of care for isolated residents).

Related Regulations:	Infection Control	SNF 405.1135
	Governing Body - Staff Development	SNF 405-1121.h
	Physical Environment	SNF 405.1134(d-i)
	Nursing Services	SNF 405.1124
	Dietetic Services	SNF 405.1125
		SNF 442.324

OBSERVATION AND INTERVIEW

12. Disaster Preparedness

Interview staff to determine if all employees have been trained in all aspects of preparedness for any disaster. This includes such problems as power outages, floods, blizzards, etc. Assure that ongoing training and periodic drills are provided for all personnel in all procedures.

Related Regulations:	Disaster Preparedness	SNF 405.1136
	Physical Environment	SNF 405.1134(a)
		ICF 442.313

CARE GUIDELINES FOR OBSERVATION OF DINING AREA AND EATING ASSISTANCE

OBSERVATION AND INTERVIEW

Serving of Food (Dietetic Services)

1. Meals are presented in an attractive manner; food is colorful and garnished. (Describe what is seen, not subjective comments when documenting this issue.)

2. All food plates are covered, and food is served at safe temperatures (i.e., milk should not be placed on the tray if it is on a heating cart). Cold foods served at 45 degrees or below; hot foods served at 140 degrees or above.

3. Taste several types of meals (e.g., special diets) at different mealtimes. Determine if pleasant to temperature, taste, and consistency.

4. Observe that residents are prepared for the meals (i.e., placed in sitting position, clothing is protected, overbed table ready and in place, and trays are promptly served).

5. Flatware, dinnerware, glassware, and trays are not stained, cracked, or chipped.

6. Uneaten food -- observe the residents during mealtime. If they do not finish at least 75% of their meals, ask them why. Are substitutes offered, and are they of equal nutritive value?

RECORD REVIEW

7. Do meals conform to the physician's orders -- compare the meal served with the diet card (i.e., portions, consistency, and seasonings).

8. Check menus and observe meals served to determine whether they are nutritionally adequate and reflect the basic four groups.
-- 2 or more servings of milk or milk products
-- 2 or more servings of meat (6 ounces) per day
-- 4 or more servings of bread/cereal
-- 4 or more servings of fruit/vegetables

9. Check to see if intake and output has been followed, recorded, and the nursing staff aware of resident's nutritional needs.

It is not necessary to observe sample residents during mealtime except those with special dietary needs and those requiring assistance with eating.

Related regulations: Dietetic Services SNF 405.1125
ICF 442.332(a)

OBSERVATION AND INTERVIEW
Observation of Eating (Supervision of Resident Nutrition) (Nursing Services

When observing for problems surrounding the ADL of eating, you should determine whether or not the staff is providing proper assistance, including whether the assistance is timely after the food has been served. Exercise judgement in determining whether or not assistance is timely. Also, residents who need less assistance (uncovering dishes, setting up utensils, encouragement) may receive staff attention first. Thus, uninterrupted time is reserved and ensured for those residents who need more assistance (spoon feeding, retraining in eating skills, or supervision). However, residents should not sit waiting for meal service for long periods of time. A food tray left uncovered, untouched, and out of the reach of a bedfast resident for a long time period would prompt you to ask questions of the resident and the staff as well as to check the food temperature.

Direct your observations to the assistance provided by staff to determine if the resident is being rushed or treated in an uncaring, undignified way. Observe whether assistive devices are available and in use and whether the staff appears to be aware of the resident's limitations or problems and provide assistance accordingly.

The following observations should prompt you to question residents and staff: a resident having difficulty eating without assistance; a resident who appears to be in need of self-help devices (which are not available); or a tray left untouched and out of reach of bedfast or chairfast residents. A closed door at mealtime may signify the resident's desire for privacy especially if the resident is light care and able to feed himself. This right should be respected, and the resident should not be interrupted for questioning.

Related regulations: Nursing Services SNF 405.1124(f)
ICF 249.12(a)(9)(v)

CARE GUIDELINES FOR OIRR

The purpose of the Observation, Interview, and Record Review (OIRR) Guidelines is to provide criteria for completing the Observation/Interview/Record Review portion of the Federal Long Term Care Survey tool. The material is designed to facilitate the application of consistent, objective, and reliable survey criteria in the completion of the in-depth resident review. This is not intended as an inclusive listing of all items a surveyor should investigate, but rather as an aid to the surveyor in learning to apply the Federal Long Term Care Survey instrument.

Prior to interviewing the resident, obtain the resident's approval. During the interview, employ a conversational tone rather than posing repeated direct questions. The surveyor's observation should lead to questions naturally. The suggested interview questions are suggestions only. The surveyor should exercise professional judgement during the interview, based on the type of observations made. If at any time during the interview the resident indicates the need to stop the process, the surveyor will honor that.

Also, respect the drawn curtain or closed door as the resident's right to privacy. During the time when morning cares are typically done, a closed door or drawn curtain may signify that the resident is bathing, dressing, etc. The resident's right to privacy is to be respected, therefore knock before entering and use discretion at all times.

NURSING SERVICES
ACTIVITIES OF DAILY LIVING (ADLs)
OBSERVATION

A. Observation Guidelines

Surveyors should arrange to observe residents who are in need of assistance with activities of daily living (ADLs) in order to evaluate the actual care provided to these residents. In instances where the care is inappropriate, note the problem on the Observation/Interview Outcome Checklist. Surveyors must use these observations to document inappropriate interventions in each resident's care. Such information should be documented in the resident record review section.

The facility should have an individualized program established for each resident in need of assistance with ADLs and restorative nursing. Most residents will require such a program or will need a maintenance program to prevent deterioration from their current level of functioning. The primary functions included in restorative nursing are: bathing, grooming, toileting, dressing, feeding, transferring, ambulation, turning, and positioning.

The surveyor should observe the staff carrying out as many facets of the restorative nursing program as possible without invading the privacy of the residents. Emphasis should be placed on staff knowledge of the plan and provision of assistance as scheduled. Staff should employ proper techniques in order to minimize resident's pain and discomfort, demonstrating an awareness of resident physical limitations. Surveyors should also observe that facility staff is provided with and uses equipment necessary for resident needs.

INTERVIEW

Suggested interview questions are:

1. What assistance do you need with bathing and/or dressing? Who helps you?
2. Does the staff plan with you your dressing/bathing schedule?
3. Are you able to dress/bathe at times convenient for you; or is it at staff's convenience?
4. Are you bathed consistently? (i.e., on the day(s) scheduled does the bath get performed)?
5. Are there adequate clothes available for you to wear?
6. Do they come back from laundry in appropriate condition?

7. How do you get around the facility?

8. How do you get in and out of bed?

9. If staff assists you, do they seem to be able to do their job appropriately? Do you always feel safe when being helped?

10. Are staff members encouraging you to do things for yourself?

11. Do you have any problems getting to the bathroom on time? Do you have any problems with leakage when you sneeze, laugh, or at any other particular time? Do you have any burning or discomfort when you urinate? How does the staff help you with these problems? Are they aware of the problems?

12. Do your bowels move regularly? If not, what do you/staff do about this? Any problems generally with bowel movements?

13. Are you able to feed yourself? Are you able to get to the dining room by yourself? If not, why? In that case, what does staff do about this?

14. How long have you been up today? Do you usually lie down for a nap? If you need help getting into bed, is staff available to help you when you need it?

15. What time do you go to bed at night? Is this your choice or staff availability/convenience?

16. Are you able to get help during the night if needed? What kind of help is needed? Is staff response timely?

17. Do you feel there are adequate care supplies at this facility? If not, can you give me an example of why you feel this way?

18. Do you feel there is adequate staff at this facility? If not, can you give me an example of why you feel this way?

RECORD REVIEW

ADLs -- Record Review Guidelines

A. Assessment

Medical records should show evidence that all residents are assessed for the need for a restorative nursing program. The assessment should clearly identify the resident's need for a program that will restore or maintain any function and prevent deterioration. It should address the resident's need for assistance in ADLs (bathing, dressing, toileting, transferring, feeding, continence, etc.) as appropriate for the resident.

B. Plan of Care

The restorative nursing program should be incorporated into the resident's overall plan of care. The surveyor verifies through interviews with staff and review of the medical record that all staff are aware of the restorative plan of care and are following the plan. Where indicated, a rehabilitative therapist, such as a physical therapist, should develop a plan of treatment for the nursing staff to carry out. All services should be involved, where indicated, in developing, reviewing, and reevaluating the plan, assessing the resident's progress, and revising the plan if necessary.

The plan of care should clearly indicate:

- Specific goals to overcome, improve, or prevent deterioration in the problem identified.
- Specific methods that will be used to accomplish the goal.
- The services necessary and the individuals who will perform the services.

C. Intervention

The surveyor should verify that treatment and procedures indicated in the restorative nursing plan of care are rendered as scheduled. Resident responses to treatment, especially significant changes in response, and the observations of other residents and staff involved in providing care, should be noted.

D. Evaluation/Reevaluation

Documentation should indicate that the resident has been evaluated for attainment, or progress toward attainment, of the goal(s) addressed in the care plan. If the goal(s) has not been met, documentation should indicate possible reasons why (i.e., deterioration of resident's condition). Revision of the goal may follow as appropriate.

NURSING SERVICES
GROOMING AND PERSONAL HYGIENE
OBSERVATION

A. Observation Guidelines

Surveyors should observe the basic care provided by staff to the residents. Listed below are suggested areas of attention which may provide evidence of poor personal care:

- Eyes/Ears/Mouth
  - Secretions forming around eyelids, redness or irritation of eyes.
  - Backs of ears scaly, obvious wax build-up, discharge, odor.
  - Dried food particles or drool, etc. around mouth.
- Odors
  - Presence of unusual body odors, determine source, check bathing patterns.
- Hair/Scalp
  - Hair is dull and dry.
  - Scaling present.
  - No evidence of regular shampooing, combing, or some degree of arrangement (hair cut or style) consistent with a positive self-image.
- Facial Hair
  - Male resident is not shaven or beard is not groomed. Excessive hair from female facial area is not clipped.
- Oral Hygiene
  - Teeth do not appear clean.
  - Bad odor.
  - Dentures are not clean.
  - Dentures do not fit properly.
- Nails
  - Resident's fingernails and toenails are not clean.

- -- Nails are not kept clipped and trimmed and interfere with skin integrity.

- o Feet
  - -- Evidence of poor foot care, such as corns, callouses, ingrown toenails, or other problems which may not be receiving attention.

- o Clothing
  - -- Inappropriate and/or unclean clothing: large tears, missing buttons, clothing frayed, too large or too small, inappropriate for season, or inappropriate for time of day or location (in bed, lounge, dining room).
  - -- Worn or frayed footwear or none available.

- o Privacy During Personal Care
  - -- Privacy curtains are not drawn, or doors are not closed during resident care.
  - -- Resident is not properly draped (privacy apron, blanket, etc.) during care.

- o Other
  - -- Resident's immediate environment (i.e., wheelchair, walker, cane, room, etc.) unclean and not maintained.

INTERVIEW

B. Interview Guidelines

Be careful that your observations are not biased by your own values, or that you do not invade the privacy of the resident. For example:

A resident's personal preference may be to wear slippers and a housecoat or morning dress throughout the day. While this could be considered "inappropriate dress" in the strictest sense, the resident's preference should be considered.

A resident may prefer to arrange room and personal belongings to suit his/her personal tastes. As long as such factors as safety and rights of other residents are considered and not infringed upon, the resident's choice should prevail.

Again, in both of these instances, a resident's personal preference should be weighed against its effect on that individual and the other residents' health and safety.

INTERVIEW

Questions should not be directed to all residents indiscriminately -- but to those for whom you may need to validate your observations. For example, if a resident is poorly dressed or clothing is frayed or worn, you should begin to clarify your observation by asking about his or her preferences. You should then ask for permission to see the wardrobe or closet to determine if other clothing is available.

A resident who is appropriately dressed in clean clothing which is in good condition would not warrant questions directed toward his or her preferences or an investigation of the closet to determine the supply of clothing.

Suggested interview questions include the following:

1. If the resident's clothing is inappropriate, ask whether he/she has other dresses or clothing available? If not, why?

2. If the resident is not clean, poorly groomed, orinappropriately groomed, ask the resident if this task is done independently or does staff help? Attempt to determine if poor grooming is per the resident's choice, is a short term issue while the resident is (re)learning skills, or whether it's due to staff carelessness, staff shortage, etc.

RECORD REVIEW

Grooming and Personal Hygiene -- Record Review Guidelines

A. **Assessment**

All residents should be assessed for any problems, needs, or limitations in carrying out daily grooming and personal hygiene activities, and whether or not they are independent, dependent, or need assistance or supervision for an activity.

B. **Plan of Care**

The plan of care should clearly indicate the:

- Specific resident problem, need, or limitation.

- Specific goals to overcome or improve the problem, need, or limitation.

- Methods to accomplish the goal including who will be responsible for providing any needed assistance, supervision, instruction, etc. and when or how often.

Observation and interview may impact on reviewing the documentation for such specific information as:

- Evidence of appropriate input from social service staff or staff of other disciplines to encourage the resident who refuses to bathe to attain a goal of regular bathing, or evidence that staff use appropriate methods to encourage a resident who refuses to change clothes or wear shoes that fit.

- A special bathing schedule or plan.
- The need for, or use of, special lotions or soaps.

Instructions or training for the resident in foot care or a schedule for giving foot care (especially if the resident has peripheral vascular disease or diabetes).

- The need for podiatry consultation.
- The need for dental consultation.

C. Intervention

Nursing notes should indicate that the care plan for grooming and personal hygiene is being followed. For example:

- Bathing schedules are being followed (including the use of any special lotions or soaps).
- Assistance instruction and/or supervision is being provided as identified for each activity.

Nursing notes should also indicate resident response or any changes in the resident's behavior, reaction to an activity, or the ability to carry out grooming and personal hygiene activities. Look for indications of progress toward a goal or further deterioration of resident functioning.

D. Evaluation/Reevaluation

Documentation should indicate that the resident has been evaluated for attainment or progress toward attainment of the goal(s) addressed in the care plan. If the goal(s) has not been met, documentation should indicate possible reasons why (i.e., deterioration of resident's condition). Verify that:

- The resident has been reassessed in order to identify changes in needs and abilities to carry out grooming and personal hygiene activities.
- New goals and methods, if necessary, have been included in the care plan with appropriate input from other disciplines.

NURSING SERVICES
POSITIONING
OBSERVATION
A. Observation Guidelines

The surveyor should observe residents, whether in bed, chair, restrained, etc. for body alignment and positioning and for the presence of protective devices if indicated. In the case of contractures, attempt to determine if the contractures developed while in the facility or if the resident was admitted with them. If they developed while in the facility, determine when and why this happened (i.e., did the facility practice appropriate restorative care aimed at prevention). Determine the specific roles of physical therapy and nursing in the area of contracture prevention/treatment (i.e., is it physical therapy's responsibility totally, is it nursing's responsibility totally, or is there a combined effort). Staff clearly understands the roles played by other departments. If this is not clear, investigate and decide whether this role confusion has impacted negatively upon the resident's condition.

The facility should have a program for all residents needing range of motion (ROM) exercises. This program should include, at a minimum, residents who have had strokes, are confined to bed or chair, have limited mobility, have contractures, etc.

A range of motion program takes a resident's joints through their extent of movement and maintains joint functions, prevents deformities from muscle/tendon shortening, and helps maintain muscle tone. Observe the provision of these treatments for the use of appropriate techniques and compliance with the plan of care. In addition to range of motion exercises, the facility should provide other care and treatment as appropriate for the prevention or correction of joint deformity. This may include such things as overhead pulleys, gloves with velcro to attach to a paralyzed hand, slings, canes, or wands used for range of motion exercises, or splints for preventing wrist and finger deformity. These pieces of equipment and accompanying programs should be appropriate for the needs of the resident and be well maintained. The surveyor may also identify that range of motion or other preventive/treatment programs are needed by the resident, but not provided by the facility.

Evaluate whether the helpless resident is being turned and repositioned appropriately and on a routine basis. A good rule of thumb to use is that the area of the body upon which pressure will be reapplied once turned should not still be reddened from the most previous turn onto that area. If it is, it indicates that circulation has not yet returned to normal and the resident must be turned more frequently. Residents should appear comfortable once positioned by staff.

Appropriate devices should be in evidence in order to maintain position (i.e., sand bags, extra pillows, footboards, etc.). If the surveyor determines that turning is not being performed as needed, or as appropriate, further observations and interviews should be focused in this area.

INTERVIEW

B. Interview Guidelines

Interview the resident and staff to ascertain understanding of the reasons for contracture prevention and routine positioning. Interview staff to determine their knowledge of the proper techniques for ROM and positioning. Both the resident and the staff should exhibit a good understanding of why turning schedules should be maintained. Suggested interview questions are:

1. How often are you turned by staff? How does staff assist in this?
2. Are you comfortable now?
3. Do you have any pressure sore points that have resulted from lack of turning?
4. How long have you had contractures? Do you know how they developed? What is staff doing about them?
5. Do you use or wear any special devices? Consistently? Are they always applied and removed appropriately and timely?

RECORD REVIEW

Positioning -- Record Review Guidelines

There may or may not be a physician's order for passive range of motion in the record as this is a nursing decision that can be made without a physician's order. Frequency of turning and the need for appropriate positioning of extremities is also a nursing decision; although at times a physician may order this as well.

A. Assessment

In some facilities the assessment may be done in conjunction with the physical therapist and the nurse. The resident should be evaluated on admission for any limitations in joint function. The resident should also be assessed for frequency of turning and repositioning.

B. Plan of Care

The plan should include:

- Short and long term goals.

- The specific joint(s) to be exercised or put through range of motion as well as the devices to be utilized for positioning.
- Recommended frequency of treatment and/or repositioning.
- Resident teaching information.
- The person responsible for carrying out the procedure(s).

C. Intervention

Nursing notes should clearly indicate that the plan of care has been implemented and progress toward goals has been addressed. If flow sheets are used to document procedures, they should be initialed at the time the treatment or repositioning is completed. Documentation of appropriate measures taken in response to change in condition should also be evident (i.e., contracture worsens, what does staff do about it?).

D. Evaluation/Reevaluation

Documentation should indicate, at least quarterly, that the range of motion and positioning/turning program has been evaluated and that progress, deterioration, or the development of new problems has been addressed. The care plan should be revised with any changes addressed. Goals should also be reassessed at this time and addressed. The notes should clearly show the intervention of other disciplines as appropriate to the resident's problems.

NURSING SERVICES
SKIN CONDITION
OBSERVATION
A. Observation Guidelines

Observation should be made to determine the general condition of the skin on the face, arms, legs, and trunk of residents; the measures used to prevent skin breakdown in inactive residents; and the care and treatment provided to a sample of residents who have pressure sores or decubitus. As with contractures, if the decubitus developed after admission to the facility, the surveyor needs to identify when and why this happened. Were adequate interventions used consistently in an attempt to prevent the decubitus?

A resident's skin ideally should be dry, soft, pliable to the touch and warm (not wet, damp, or too dry). A surveyor can determine this by including in a greeting appropriate touching, such as a light handshake or a touch to the forearm. Appropriate touching depends upon the resident's receptivity to the surveyor and the purpose of the visit to the facility. The resident's receptivity may also depend on his/her degree of alertness and behavior.

Some skin problems can be immediately observed (e.g., rashes, irritations, bruises, or wounds on the face, arms, or legs). Other skin problems, particularly problems with integrity under clothed or covered areas of the body are less easily discernible without asking about their presence. Once it is discovered that skin problems exist on areas of the body that are clothed or covered, arrange for a time to have the Director of Nursing or charge nurse remove the resident's bed covering and clothing in order to verify this skin condition. The resident should not be disturbed or interrupted unnecessarily. If possible, this in-depth observation should coincide with treatment time in order to observe the actual delivery of treatment(s) and care (washing, massage, turning, positioning, changing of dressing). This observation will allow the surveyor to evaluate the knowledge of the staff regarding resident needs and the appropriateness of treatments and procedures rendered. Good observation techniques are necessary for this portion of survey. The rule of thumb described under contractures for assessing the length of time that skin remains reddened after turning is useful for this section also (e.g., if the area to be turned onto is still reddened from previous turnings, the blood supply to the affected area has not yet returned to a normal state, hence turning is not occurring frequently enough). Commonly, facilities use an every two hour guide for turning. However, some residents need to be turned more frequently, and utilizing the above described rule of thumb will assist in making this determination.

The surveyor should observe bedfast or chairfast residents regularly throughout the visit to determine whether or not turning, positioning, and/or assistance to ambulate or transfer the resident is provided regularly to prevent skin breakdown. Observe:

- If the care has been documented on the medical record according to the plan of care.

- If the resident's position agrees with that indicated on the record.

If pillows or other supportive devices are placed appropriately to support the resident's position and prevent skin contact (between knees, in groin area, behind back, etc.). Also check between the resident's toes for skin problems and whether appropriate material is placed between them as necessary to prevent any problems.éLM12ë

- If bedrails, trapeze, etc., are available to aid residents in shifting their weight.

Rashes or irritations may result from drug therapies or allergies. Residents who are terminally ill, comatose, emaciated, or paralyzed are at high risk for development of compromised skin integrity. These elements should be taken into consideration when observing general skin condition.

Decubitus ulcers are graded as follows:

1. Pre-Ulcer (characterized by unbroken skin surface).
   An area of induration, erythema, or blue/black discoloration of the skin which does not fade within 30 minutes after pressure has been removed.

2. Ulcer (characterized by broken skin surface).

   Grade I -- A moist irregular partial thickness ulceration limited to the superficial epidemal and demal layers.

   Grade II -- A full thickness extending into the subcutaneous adipose tissue.

   Grade III -- A necrotic ulcer extending into muscle.

   Grade IV -- A necrotic ulcer extending into bone or joint structures.

Listed below are observations which may need to be noted as inappropriate interventions.

Inappropriate Preventive Measures

- Lack of overall cleanliness and maintaining dry and aerated skin (uncompromised by urine/feces/perspiration.
- Lack of padding for pressure points and bony prominences.
- Lack of proper massage to stimulate venous blood flow.
- Lack of regular assistance for resident to turn or shift weight (bedrails, footboards, trapeze).
- Bed linens, clothing, underpads not smooth and free from wrinkles.
- Lack of dietary/nutritional support for skin integrity. (See Guidelines for Dietary/Nutrition.)
- Presence of shearing force when resident's position altered by staff.
- Lack of turning and repositioning as needed.

Inappropriate Decubitus Care and Treatment

- No turning and repositioning every two hours or as needed.
- Lack of positioning off the ulcer site or protection of affected area.
- Lack of nutritional intervention and support.
- Lack of appropriate techniques to prevent infection.
- Lack of keeping area dry, clean, and uncompromised by urine/feces/perspiration.
- Use of shearing force when resident's position altered by staff.

INTERVIEW

B. Interview Guidelines

Residents who are able to talk with the surveyor will be able to provide good data regarding the current status and history of their skin. It is appropriate to ask a resident about his/her swollen feet or red, bluish, or mottled skin on the legs, for example, if the resident is sitting in a chair without the legs elevated. The presence of a wound or bruise would naturally prompt a question about its occurrence. However, the resident may not want to discuss an accident which may have caused the injury. Resident input for this indicator can be an important source for further observation and record review. Secondly, it is appropriate to direct questions to the staff regarding their knowledge of the resident's condition and needs as well as the plan of care. This is particularly important if poor care is evident (e.g., residents have not been turned and repositioned every two hours, transferring assistance is not being rendered, creams or lotions are not available for massage). Even if poor care is not evident and the resident is at risk, staff should be asked about the elements of preventive skin care. Staff interviews help the surveyor in coming to conclusions about decubitus ulcers that developed in-house, in terms of whether the facility provided inadequate care/prevention that caused the occurrence.

Suggested questions are:

1. How did your skin problem develop?

2. What is staff doing about this?

3. Do you feel comfortable with the skills of the staff (i.e., do they seem to know how to perform the treatments)? Are they performed in a timely fashion and in a consistent fashion?

RECORD REVIEW

Skin Condition -- Record Review Guidelines

This section includes both general skin care and specific decubitus care. Attention should be directed toward determining whether or not planned preventive procedures are documented or special treatments -- including nutritional intervention -- are identified for all residents at risk of developing decubitus (i.e., inactive, incontinent, undernourished residents) and for those who have decubitus ulcers.

A. Assessment

Assessment information should indicate that the facility is aware of the resident's skin condition including potential for deterioration. Documentation should indicate that skin surfaces are looked at regularly for the resident at risk or residents exhibiting any rash, irritation, or other problem. Regular nursing observation should address skin surfaces that touch each other (between toes, groin, under breast, between legs, under arms, bony prominences). Other information which should be documented:

- Specific location of the skin problem -- the number, site, degree, and measurement of decubitus ulcers.

- Clear indication of contributing factors to the development of the skin condition.

- For decubitus ulcers developed in-house, documentation must include cause of decubitus and substantiation of preventive interventions.

B. **Plan of Care**

The care plan should clearly indicate awareness of the resident's problem, the goals, methods and procedures to be used, and staff responsible for implementing care. The plan should include:

- Skin care procedures to prevent infection, irritation, drying out of skin as well as promotion of circulation.
- Established turning and positioning schedules to prevent undue pressure, decubitus ulcers.
- Schedules for assisting residents to transfer or ambulate.
- The number, site, and stage of each decubitus ulcer and appropriate care and treatment.
- Use of special creams, lotions, medications, or protective devices.
- Appropriate nutritional plan (increased caloric intake to promote healing as well as to maintain serum protein and iron levels).
- A method for ensuring adequate hydration.

C. **Intervention**

Nursing notes should indicate clearly that the care plan is being implemented. Documentation should address:

- Degree of successful prevention, progress toward healing, or further deterioration.
- Any changes in the resident's condition or response to treatment.
- Appropriate measures taken in response to a change in condition (such as observation of a reddened area and action).

The cause of a bruise or wound should be documented and, based on the cause, appropriate intervention should be instituted to prevent reoccurrence (e.g., assistive devices, training, vision check, neurological consult, or evaluation of other medical conditions).

If flow charts are used as documentation in lieu of nursing notes, they should clearly indicate that the treatment is rendered regularly, results of that treatment, condition of the ulcer/wound, and that dates of occurrence of a skin problem or pressure sore are noted along with date of resolution of the problem. These forms should also include the initials of staff that correspond with name and title.

D. **Evaluation/Reevaluation**

Documentation should indicate that the resident has been reassessed when significant changes have occurred as well as on a periodic basis. The staff notes should indicate progress, deterioration, or the development of new problems. The notes must clearly show the intervention of other disciplines as appropriate to the problem including recommendations from consultations. It should be evident that goals are being modified based upon the ongoing assessments.

NURSING SERVICES
WOUND DRESSINGS
OBSERVATION

A. Observation Guidelines

The surveyor must observe that dressings are clean, dry, and intact. Attempt to be available at the scheduled time for a dressing change or treatment. If unable to be present at the scheduled times, request that the dressing be removed so that you can observe the wound. The old dressing should be examined prior to disposal to note drainage, specifically, the amount, color, odor, and consistency. Also, note any reaction on the skin to the type of tape used.

Observe the preparation for the removal of the dressing and the treatment to be performed. Questions should be asked of the nurse as to the type of treatment ordered and the frequency. Properly labeled dressing equipment and biologicals should be available in sufficient amounts for the procedure.

Aseptic and/or sterile techniques should be observed including the proper disposal of the soiled dressing.

Observe the wound, decubiti, or incision and the tissue and skin surrounding it for size, condition of the tissue, necrosis, redness, swelling, etc. If sutures or drains are present, observe their condition, and the potency of drains, if possible.

INTERVIEW

B. Interview Guidelines

The surveyor should interview the resident to determine if he or she is comfortable during the dressing procedure.

The surveyor should interview staff regarding:

- Specific treatment and schedule for each resident.
- Their training in aseptic and sterile techniques.

Suggested questions for resident are:

1. What caused the ulcer, wound, etc? Is it healing? Does the staff keep you informed of its status?
2. How frequently is it changed? Is it changed timely and consistently by staff? Do the staff changing it seem knowledgeable about the procedure? Who changes the dressing (nurse or aide)?
3. Is the open area/wound healing?

RECORD REVIEW
Wound Dressings -- Record Review Guidelines

A. **Assessment**

The surveyor should verify that there are current physician's orders pertaining to the type and frequency of treatments as well as nursing documentation indicating that the orders are being followed. Documentation of the area requiring the dressing should include size, depth, color of tissue, necrosis (if any), drainage (if any), and odor.

B. Plan of Care

The plan of care should address:

- Area in need of treatment, treatment to be performed, frequency, and responsible staff.
- All necessary solutions, ointments, irrigations, types of dressings, and materials.
- Any necessary precautions, drains, if present, sutures and tubing.
- Short and long term goals as well as any problems or limitations imposed as a result of treatment.

C. Intervention

- Nursing progress notes should indicate that treatment is being carried out at specified intervals by responsible staff.
- The record should also reflect any changes in treatments or conditions and the reasons for such changes.
- The record should include detailed descriptions of the condition of the area being treated such as redness, swelling, an objective description or measure of size and depth of area, odor (if any), drainage, and condition of dressing, if drainage is present.

D. Evaluation/Reevaluation

- Documentation should indicate assessments at specific intervals of treatment effectiveness, including measures used to enhance healing such as protective padding, positioning, etc.
- Documentation of the response to treatment should reflect any change in the condition of the resident. Lack of progress should result in additional nursing interventions or a planned decision to continue for a specified length of time with the current treatment.

NURSING SERVICES
RESTRAINTS
OBSERVATION

A. Observation Guidelines

Observation should be directed at evidence of proper application or use of restraints, maintenance of good body alignment, and whether the resident is observed, released, and exercised at regular intervals. Therefore, restrained residents should be observed closely and frequently throughout your visit to validate that staff are providing the necessary care and noting resident response or behavior.

Observe residents for evidence of any chafing, swelling, or discoloration which may indicate inappropriate application of restraints, or lack of release and opportunity for motion (at least every two hours). Specific observations should include the following items:

- Type of restraint: posey belts, wrist or ankle cuffs, blanket restraints, vests, bed nets, etc., as well as geriatric chair (or geri-table in place for prolonged periods).
- Appropriate application: skin protected from injury (restraint neither too loose nor too tight to prevent rubbing and blistering or impeded circulation).
- Body alignment and support: use of pillows, footboards, and wheelchair footrests to maintain appropriate posture, circulation, and to prevent skin injury or breakdown.
- Periodic release and exercise: exercise may include ambulation, range of motion, massage, or other opportunities for motion (at least 10 minutes every 2 hours).
- Chemical restraints: residents appear drowsy and unresponsive throughout the day (may indicate tranquilizers or other drugs are being used to limit or control behavior for staff convenience).

INTERVIEW

B. Interview Guidelines

This indicator relies more on observation and record review than extensive interviewing of residents. Because the use of restraints may be precipitated by an "emergency" situation in which there is a threat to the resident's health or safety, or a threat to the health and safety of others due to the resident's behavior, restrained residents may not be coherent or rational enough to respond to questions. Caution in interviewing, therefore, must be exercised. However, observation of a resident in a geri-chair with table in place or a resident in a wheelchair (with vest restraint) for several hours would warrant an appropriate question as to when the staff last assisted him or her to move about or whether the resident would like to get out of the chair. Staff interviews focus on the reason why the resident is restrained and whether the original reason for restraint still exists. Staff should be knowledgeable about when, why, and how to release and apply restraints.

If chemically restrained, the staff administering medications should be knowledgeable in all aspects of why this is done, whether alternate means of restraint have been attempted, for how long this will continue, etc. This should elucidate from staff whether the chemical restraint is necessary, or whether it is done for staff convenience by controlling resident behavior.

Suggested questions are:

1. Why are you restrained?

2. How often do you wear the restraint?

3. What would happen if the restraint were removed?

RECORD REVIEW

Restraints -- Record Review Guidelines

Documentation should clearly indicate that restraints are being used in emergency situations where resident health or safety is threatened and that they are being used in accordance with a physician's order.

A. Assessment

Information should describe the resident's mental status/behavior which prompted the use of the restraint. The physician's orders for the restraint should indicate a specific reason for its use. If a chemical restraint is ordered, the order should indicate a specific time period for its use as well as a stop date.

B. Plan of Care

The plan of care should:

- Identify other methods or therapies that are being used in conjunction with restraints to modify or control behavior.

- Identify staff responsible for observing the resident (every 30 minutes), and releasing and exercising him/her (every 2 hours for at least 10 minutes). Time intervals should be identified.

- Indicate involvement and input of other disciplines necessary to overcome the problem.

- Indicate a specific period of time for using the restraint (e.g., orders not enforced for longer than 12 hours, unless resident condition warrants).

C. Intervention

Documentation should support that:

Staff has observed the resident regularly, and the resident has been released and exercised as scheduled.

- Drugs, such as tranquilizers, are being administered in accordance with physician orders.

- Resident responses, development of new problems, or changes in the resident's condition are noted as well as staff responses.

D. Evaluation/Reevaluation

- Reorders for the use of restraints are issued only after a review of the resident's condition.

- The resident's mental/behavioral status has been reassessed. The care plan addresses new resident needs, appropriate goals, and methods to meet them.

NURSING SERVICES
INJECTIONS
OBSERVATION

A. Observation Guidelines

Of all the routes of medication administration, injections are the most hazardous. Once the surveyor has determined that a resident is receiving regular injections, the following observations should be made:

- o Look to see that injection sites are not reddened and/or swollen. Injection sites must be selected carefully so as to avoid major nerves and blood vessels. Nurses should not select areas where lesions, inflammations, or birthmarks exist.
- o Needles and syringes (clean and/or dirty) should not be left in any of the resident care areas.
- o If the opportunity arises to observe an injection, check that appropriate techniques are used. Note that the needle selected is the proper length for the injection and the resident's body size, that the nurse checks for blood backflow (draws back on plunger) before injecting, and maintains sterility throughout the procedure.
- o Determine that the resident displays no adverse reactions to the injection.

INTERVIEW

B. Interview Guidelines

The surveyor should attempt to establish that:

- o The nurse is alternating injection sites according to a systematic plan.
- o There is no nonspecific pain at the injection site or shooting pains down a limb.
- o There are no skin irritations or lumps under the skin.

Suggested questions are:

1. What kind of medicine do you receive by injection/shot? Why do you need that medicine?
2. Do you have pain or numbness at or around your injection site?
3. Who gives you the injection?

4. Do you receive your injection according to a schedule?

RECORD REVIEW

Injections -- Record Review Guidelines

The surveyor should determine that injections are administered in accordance with physician's orders and that the route of administration is specified.

A. **Assessment**

The record should indicate the necessity for the injection as opposed to any other route of administration, as well as the desired effects. The nurses notes should reflect any skin problem noted at the sites and should be specific as to appearance, size, etc.

B. **Plan of Care**

For residents receiving regular injections, a site rotation plan should be developed. Where skin problems or adverse reactions have developed, the plan of care should include the approach toward correction as well as prevention of further or additional problems. The plan should be specific as to treatment, time frames, and responsible person.

C. **Intervention**

Documentation should reflect exactly what injection was given, where it was given, and by whom.

D. **Evaluation/Reevaluation**

Attention should be directed toward the resident's response to the injection both medically and emotionally. The record should reflect any positive and/or negative findings and based on these, further interventions as necessary.

NURSING SERVICES
PARENTERAL FLUIDS
OBSERVATION

A. Observation Guidelines

The surveyor should observe that parenteral fluids are administered with safe, aseptic technique providing fluids as ordered by the physician. Safety and comfort measures are to be taken insuring maximum protection and optimum hydration of the resident.

The surveyor should note the following items:

- Labeling of the solution bottle/bag.
- Rate of infusion/hour.
- Date and time started -- additions, if any.
- Any signs of swelling or redness at site.
- Site dressing is clean and dry.
- Accurate I&O of parenteral and P.O. fluids.
- If splint (armboard) is used, it is applied to prevent movement but not impede circulation.

INTERVIEW

B. Interview Guidelines

The surveyor should ask the resident if he or she is comfortable while receiving IV therapy. The surveyor should interview staff regarding their training in IV therapy. Suggested questions for residents are:

1. For what reason do you have this tube in your (arm) (leg)?
2. Is it uncomfortable?
3. Do you have any problems with it?

RECORD REVIEW

Parenteral Fluids -- Record Review Guidelines

The surveyor should note that:

- Physician's order for parenteral therapy specifying type of fluid, rate of infusion/hour, and additives, if any, is available and current.
- Twenty-four hour I&O record is maintained accurately.

- Nursing documentation indicates physician's orders are being followed.
- Any adverse reactions are noted in the medical record.

A. **Assessment**

The assessment should include:

- The need or reason for parenteral fluids.
- Response to the therapy.
- Problems and limitations encountered by the resident as a result of receiving parenteral fluids.

B. **Plan of Care**

The plan of care should include:

- Type, rate of infusion/hour, and additives (if ordered).
- Frequency of site dressing change and tubing change.
- Accurate 24 hour I&O documentation.
- Mouth care, if NPO.
- Identified problems or limitations, including specified goals for correction, time frames, and responsible staff.

C. **Intervention**

Intravenous and/or antibiotic therapy is specific as to time frame (doses or number of days). Documentation must include time administered and by whom, the amount of fluid infused, and any other special care administered as a result of IV therapy (i.e., mouth care, assistance with ADLs, etc.).

D. **Evaluation/Reevaluation**

The record must reflect conditions of site and any infiltrations, phlebitis, necrosis, etc. noted, along with measures taken to correct these. The resident's response to therapy must include the effects of IV therapy rehydration, additives, etc. Changes in laboratory studies should be taken into account. Evaluation of alternative methods of hydration and nutrition should be considered as appropriate. Residents response to the program should be noted.

Goals should be modified as needed based on progress or lack of progress and further interventions may be indicated.

NURSING SERVICES
BOWEL AND BLADDER
OBSERVATION
A. Observation Guidelines

Bowel and bladder training is an intensive program which requires staff time and commitment. Simply planning to toilet the resident every two hours is not a bowel and/or bladder retraining program.

The surveyor should verify that the resident is aware that he/she is on a retraining program and the content of the program. There should be a chart/record in the resident's room on which the program is documented accurately. The resident, if able, may be involved in this documentation. If the room is located a distance from the toileting room, a commode may be present in the room for the convenience of the resident.

The surveyor should verify that a call light is available to the resident if nonambulatory or restrained, in order to alert staff to the need for toileting. Residents with problems ambulating should have a commode at their bedsides to decrease incidences of incontinence.

Residents with a long history of urinary/fecal incontinence, suffering from a dementia, and/or suffering from neurological deficits may not be ideal candidates for a retaining program. Recently admitted, incontinent residents should be thoroughly assessed as the incontinence may be a result of an acute illness or recent hospitalization.

INTERVIEW
B. Interview Guidelines

Both the resident and direct care staff should be interviewed and should exhibit a good understanding of the importance of maintaining a regular schedule of elimination. If neither are aware of the intake and toileting schedule, then question whether they are simply panning the resident rather than carrying out a retraining program.
Suggested questions are:

1. Are you involved in a special bowel/bladder training program? If so, how does your program work? Any problems with it? Any successes to date? What does the staff do for you in this matter? Are they consistent and timely?

RECORD REVIEW
Bowel and Bladder -- Record Review Guidelines

The surveyor should look for a specific physician's order for a bowel and bladder retraining program in the medical record.

A. Assessment

Prior to the initiation of the bowel and bladder program, the nurse should have assessed the incontinent resident's ability to participate in and benefit from a bowel and bladder retraining program. There should be some indication of the circumstances under which the resident voids or defecates (e.g., incontinence with no awareness; aware of urge; and usual times (weekly chart) of incontinence).

B. Plan of Care

The plan of care should clearly address:

- Short and long term goals.
- Methods to accomplish the goals.
- Schedules for fluid intake.
- Schedule for toileting.
- Responsible staff.
- Any limitations the resident may encounter as a result of either incontinence or the training program.

C. Intervention

Daily documentation in the medical record should indicate that a program is in effect, and any progress of the resident in attaining continence.

The nursing notes should indicate progress, deterioration, or the development of new problems. The notes clearly show the intervention of other disciplines as appropriate to the resident's problem (e.g., dietary, social services, activities).

D. Evaluation/Reevaluation

Documentation should indicate that the plan has been reassessed and adjusted as the condition warrants. If the plan has not been successful in approximately four weeks, the resident should be reconsidered as a potentially successful candidate. The plan, then, should be adjusted to address the problem of incontinence.

NURSING SERVICES
CATHETER CARE
OBSERVATION

A. Observation Guidelines

The indwelling Foley catheter should promote a continuous flow of urine unless ordered otherwise. The surveyor should also observe for the following:

- o Ample supplies for catheter insertion and care.
- o Proper positioning of the tubing and drainage bag.
- o Cleanliness of the tubing and drainage bag.
- o Color and consistency of urine in bag.
- o Availability and accuracy of documentation on the I&O sheet.
- o Proper equipment for ambulation -- leg bag if resident is ambulating.
- o Availability of fluids.
- o Monitoring of fluid intake to ensure adequate intake and/or conformance with physician orders.

INTERVIEW

B. Interview Guidelines

Staff members should be interviewed in regard to their knowledge and understanding of catheter care. Determine that staff members understand the reasons for proper positioning and securing of the tubing and drainage bags, and the necessity for catheter care.

In interviewing the resident, surveyors should ask about pain or discomfort and when it occurs as well as the emotional response to the use of a catheter.

Suggested questions are:

1. What is this tubing/catheter for? Do you know why you have one? How long have you been using it?
2. Do you have any discomfort right now? Do you ever have discomfort? Do you tell the staff? What do they do about it?
3. How do you feel about using a catheter? Is it your preference?

RECORD REVIEW

Catheters -- Record Review Guidelines

The surveyor should verify that there is a physician's order for an indwelling catheter, including the type and frequency of catheter care. If irrigation is ordered, the order should include type of solution and frequency of irrigation. The record should also indicate the color, consistency, and amount of urinary drainage.

A. Assessment

Assessment should address:

- o Need for an indwelling catheter.
- o Resultant problems or limitations.

B. Plan of Care

The plan of care should address:

- o Type of catheter and type and frequency of care.
- o For irrigation, the rationale, the type of solution, amount, and frequency of irrigation.
- o Frequency of symptoms which would precipitate catheter change.
- o Time frames and responsible staff.

C. Intervention

The record must reflect when and by whom the catheter was inserted and for what reason. In addition, any special care must be documented along with new problems or changes noted. Only appropriately trained staff should deliver catheter care. Licensed staff only should insert catheters. The specific type and size of equipment used should also be noted. Signs and symptoms of urinary tract infection (UTI) should be acted upon and documented as to follow-up.

D. Evaluation/Reevaluation

The record should reflect that the resident:

- o Is assessed for UTI.
- o Has no abdominal distention.
- o Has been assessed for a bladder and bowel retraining program.

Notes should also include the color and odor of urine and the development of any problems after Foley insertion. Goals should be modified if necessary on the basis of the individual resident's condition. Lastly, records should be available as to the ratio of residents with indwelling catheters who have developed UTIs. Staff should be trained to assure that proper catheter care is performed.

NURSING SERVICES
COLOSTOMY/ILEOSTOMY
OBSERVATION

A. Observation Guidelines

The surveyor should ascertain that the facility is providing appropriate nursing care to those residents who have had bowel surgery resulting in a colostomy or ileostomy. It is recommended that the surveyor observe care being given to determine that proper techniques are used.

The following steps should be taken to assure that proper ostomy care is being provided.

- The ostomy dressing should be changed or the bag emptied and thoroughly cleaned promptly after each bowel evacuation or more frequently, if drainage continues.
- The peristomial skin should be cleansed and dried, and appropriate measures taken to prevent excoriation and infection.
- The resident's privacy should be considered while providing care.
- The resident should be provided with information and instruction in self-care at the appropriate level of understanding.
- The resident should be observed for signs of withdrawal, disgust, anxiety, or other emotional responses which may be related to his/her acceptance of the colostomy/ileostomy.
- The surveyor should observe the staff giving ostomy care to verify that proper technique is used.

INTERVIEW

B. Interview Guidelines

Staff interviews should be aimed at assessing staff's knowledge and understanding of the ostomy as well as care specific to the resident being reviewed.

Resident interview is aimed at determining the resident's response to and level of acceptance of the ostomy as well as care of the ostomy. If either is in question, the resident's perception of staff's response to that should be assessed. Finally, the resident should be queried regarding interest/ability/teaching for self-care of the ostomy.

Suggested questions are:

1. What purpose does the ostomy serve?

2. How long have you had this? Is it temporary or permanent?

3. Why was the ostomy performed?

4. How do you feel about the ostomy?

5. Does it ever cause you problems (i.e., pain, skin problems, odors, accidents)? If so, what does staff do about it?

6. What does the staff generally do with or for the ostomy? Are they consistent and timely?

7. Has staff talked to you about doing some of the care for this? If so, what was the outcome? If not, is this something you'd be interested in learning more about?

RECORD REVIEW

Colostomy/Ileostomy -- Record Review Guidelines

The surveyor should determine that:

- Colostomy irrigations, if ordered, are documented as performed by appropriately trained staff.
- Regular patterns of bowel elimination are documented as established through management of diet, fluid intake, exercise, and the use of prescribed laxatives, suppositories, and/or irrigations.
- Ostomy care is documented in the resident's record along with a description of the stool.
- Problems in irregularity, skin breakdown, or other observable concerns are documented and reported to the physician.
- Documentation indicates that nursing measures are taken to assist the resident who is experiencing problems in understanding and/or accepting the presence of the colostomy/ileostomy.
- Documentation of nursing measures to maintain skin integrity.

A. Assessment

The assessment should indicate:

- Needs, problems, and limitations as a result of a colostomy/ileostomy.
- Specific degree of self-care performed or assistance needed.

- Special skin care needs.
- Regulation and special dietary needs.
- Emotional support.
- Medications and treatments.

B. Plan of Care

The plan of care should clearly address:

- Specific goals to overcome or improve the problem(s) identified.
- Methods to accomplish the goal (training, assistance, supervision, treatments, emotional support).
- Services necessary and who will perform the services.
- Time frame for accomplishing goals.

C. Intervention

- Nursing notes should indicate that the plan of care is being followed.
- Problems are documentated as addressed through diet changes, medication, and treatments specific nursing measures.
- Training and emotional support is provided and changes in resident response or reaction (to assistance, self care) are noted.
- Observed problems are coordinated with appropriate other disciplines and resolved.

D. Evaluation/Reevaluation

The surveyor should look for:

- Documentation of attainment of goals or progress towards the goals.
- Documentation that the plan of care has been modified, if necessary, based on progress or lack of progress in meeting goal(s) or change in the resident's condition.

NURSING SERVICES
SPECIALIZED REHAB SERVICES
RESPIRATORY THERAPY
OBSERVATION

A. Observation Guidelines

- IPPB (Intermittent Positive Pressure Breathing Machine) The surveyor must determine that the facility is providing respiratory therapy as ordered by the physician. Observation for this indicator should focus on the necessary equipment as well as on the resident. In order to determine that the necessary equipment is available, the surveyor must look for the following:

-- IPPB Machine (there are many different machines which deliver intermittent positive pressure breathing therapy). Check that the machine is clean and operable.

-- Tubing -- If tubing is not attached to the machine, ask to see it. Check that it is stored dry and with consideration for cleanliness.

-- Nebulizer Cup -- Should be attached to tubing. It is filled with either the prescribed medicine or distilled water only if about to be used. It should not be stored wet. If it is not attached to the tubing, ask to see it. The mouthpiece is connected to the nebulizer cup.

The surveyor should also check that all involved equipment is clean.

- Oxygen Therapy
  The surveyor must establish that the facility is meeting the oxygen needs of the resident. When the facility does not have wall units, check that there are enough cylinders for oxygen delivery. There should be at least as many flow meters and regulators. A wrench should be attached or stored close by. When a facility is using large cylinders (size G or H), look for a carrier since these tanks cannot be transported without it.

  The cylinder at the resident's bedside should either be on the carrier, sitting in a metal skirt, or otherwise secured. This will prevent the cylinder from tipping over, and it will also discourage staff members from attempting to drag or slide the cylinder which could produce friction.

  Depending on the type of therapy the resident is receiving, there should be other necessary equipment available such as humidifiers, nebulizers, masks, nasal cannulas, T-pieces, etc. All should be dry and clean when stored.

Check to make certain the tank is not empty and that any empty tank is labeled as such.

Check for good oral hygiene of resident. Also, the room should be posted with a "No Smoking" sign.

INTERVIEW

B. Interview Guidelines

Staff interview should focus on staff's understanding and knowledge about the therapy in use for the resident. Staff working with the equipment must be knowledgeable about its use and function, as well as care specific to the resident in question. Staff should be queried as to their training and amount of experience in working with the equipment. Do they maintain a schedule for changing/cleaning tubing and equipment?

While talking with the resident, observe for sounds of congestion. Note color of lips and nail beds. Ask resident if he/she ever feels short of breath and what happens if and/or when he/she does become short of breath.

Suggested questions are:

1. Is the therapy helping you to feel better? Are you having any problems with it? If so, how does the staff respond? Is staff timely in helping you? Is the therapy consistently performed?

RECORD REVIEW

Respiratory Therapy -- Record Review Guidelines

The surveyor should determine that:

- Respiratory/oxygen therapy is performed or administered by appropriately trained staff.
- There is a physician's order for therapy, and it is specific as to rate of delivery, etc.
- If the physician's order is for prn therapy, it should specify for what symptoms.
- Any information gained from resident or staff is verified in the record.

A. Assessment

The assessment should address both the need or reason for therapy and any problems or limitations which result from the need for therapy.

B. Plan of Care

The surveyor should note:

- The kind, amount, frequency, and/or duration of therapy based on the physician's order.

- Specific goals to overcome to improve any identified problems and/or limitations.

- Specific methods to accomplish the goals (observation, supervision, training, etc.).

- Who is responsible to perform therapy or assist in accomplishment of goal.

C. Intervention

The record should display evidence that the plan of care is functional and that the therapy was administered in accordance with physician's order for the specified reason(s) by an appropriately trained staff member. Change in condition is documented as noted and acted upon promptly.

D. Evaluation/Reevaluation

The record should reflect:

- The resident's response to therapy.

- If response was undesirable, evidence of further intervention.

- Any progress, deterioration, or development of new problems.

- Based on the above information, possible modification of goals.

NURSING SERVICES
TRACHEOSTOMY CARE
OBSERVATION

A. Observation Guidelines

Satisfactory tracheostomy care is a procedure which promotes a clean unobstructed air passageway and maintains the skin integrity surrounding the tracheostomy site.

The surveyor should determine whether adequate supplies are available for the care of the tracheostomy such as tracheostomy kits, hydrogen peroxide, normal saline or sterile water, suction machine, catheter, sterile gloves, and clean dressings.

In terms of resident-oriented observations, the surveyor should verify that:

- The resident is breathing without difficulty and is comfortable.
- The dressing is clean, dry, and intact; the cannula is clean, in the proper position, and secured.
- The skin surrounding the trach is clean and dry with no redness or inflammation.
- The resident does not appear in need of mouth care.
- An extra tube is available at bedside.

INTERVIEW

B. Interview Guidelines

The surveyor should determine that staff is knowledgeable about issues, as well as aware of the frequency of the treatments, procedure, and supplies needed. Queries should be directed at determining that staff is trained and competent to care for the residents with tracheostomy.

The surveyor should determine that the resident is comfortable with the tracheostomy care.

Suggested questions are:

1. Are you feeling comfortable?
2. How often does staff check your trach?
3. What care can you do for yourself?
4. What do you need help with?

RECORD REVIEW

Tracheostomy -- Record Review Guidelines

The surveyor should determine that tracheostomy care is done as scheduled and as needed following the proper procedure. Any special solutions that are needed should be addressed in the physician's orders.

A. **Assessment**

The record should reflect that the need for tracheostomy care was assessed in terms of frequency. There should also be evidence of assessment of the skin integrity surrounding the tracheostomy, noting redness, inflammation, and/or excoriations.

B. **Plan of Care**

The plan of care should include:

- Specific times of trach care and the responsible, appropriately trained person performing this task.
- Specific problems relating to skin and breathing as well as the goals set to overcome these problems listing the appropriate personnel responsible.
- Time frames for resolving problems listed in goals.

C. **Intervention**

The surveyor should look for documentation of trach care and oral hygiene administration, including responsible personnel, time and date, and effects. Any problems or changes noted in resident condition (e.g., redness, swelling, tracheal obstruction) should also be documented.

D. **Evaluation/Reevaluation**

Documentation should indicate that the resident is or is not benefiting from trach care and skin care. If problems are noted, the progress notes and plans of care should indicate changes in treatment. Documentation relative to resident's emotional response to care of the tracheostomy should be evaluated, since this may require additional care planning.

NURSING SERVICES
SUCTIONING
OBSERVATION

A. Observation Guidelines

Suctioning is necessary for any resident who is unable to cough up secretions that are obstructing his airway. Suctioning may occur via the oral or nasal route. Attempts should be made to observe a resident being suctioned should such an opportunity arise. If so, observe that a clean technique is observed throughout and that the resident tolerated the procedure. There should not be bloody aspirant, cyanosis, or bronchospasm. Check that equipment is in good working order, frequency of procedure, etc.
Resident observations include:

- o Secretions are draining from a resident's mouth or trach and the resident is unable to cough or clean himself.

- o There are audible raes and/or diminished breath sounds.

- o The resident is dyspneic.

- o Restlessness or agiation may also be an indication that suctioning is needed. The surveyor should observe that the resident is positioned to facilitate breathing (usually at a 45 degree angle).

Suctioning cannot be accomplished where there is no suction machine and/or catheters. Check to see that the facility has an ample supply to meet the needs of residents requiring them.

INTERVIEW

B. Interview Guidelines

The surveyor should talk with staff members to determine that all necessary equipment is available and attempt to establish their understanding of proper suctioning.

The surveyor should determine the resident's response/condition to suctioning. If able to speak with the surveyor suggested questions might be:

1. Are you feeling comfortable now? Does the suctioning seem to help?

2. Has staff explained to you the need for suctioning? Why do you need to be suctioned? How often?

3. Who performs the suctioning (i.e., nurses or nurses aides)? Do you feel safe with the staff performing the suctioning?

RECORD REVIEW

Suctioning -- Record Review Guidelines

A. Assessment

The record should reflect that the resident is constantly being observed for suctioning needs. Any limitations a resident éBBëhas as a result of his suctioning needs should be specifically noted. Any problems resulting must be specified.

B. Plan of Care

The plan of care should include awareness of the resident's suctioning needs, goals, approaches, and responsible staff needed to improve the problem or at least to maintain the resident at his present status without further deterioration.

The plan must clearly indicate specific approaches towards:

- Prevention of skin problems around the trach if one exists.
- Correction of any existing skin problems.
- Provision of good oral hygiene including a rigid schedule for mouth care, schedules, or procedures for maintaining clean equipment at bedside, as well as disposal of used (dirty) equipment.
- Route of suctioning (i.e., oral/nasal/trach).

C. Intervention

The record should indicate clearly that the plan of care is being implemented. Documentation should reflect:

- The number of times the resident required suctioning, for what specific reason, and by whom the resident was suctioned.
- Any special treatment the resident received in conjunction with suctioning (i.e., oral hygiene, skin care, etc.).

D. Evaluation/Reevaluation

The record should reflect how well the resident tolerates suctioning procedures. Any bloody aspirant, cardiac arrhythmia, cyanosis, or bronchospasm must be noted as well as all further interventions utilized to overcome or improve these. The amount of sputum as well as its color and consistency must be noted. Any progress or lack of progress, deterioration, and/or the development of new problems must be assessed for further interventions, recommendations, and consultations as necessary. The evaluation should determine whether goals are being reached or if new goals must be addressed.

DIETARY SERVICES
NURSING SERVICES
DIETARY SERVICES
OBSERVATION

A. Observation Guidelines

The surveyor should first observe the appearance of each resident in the sample which might be indicative of possible nutritional problems (i.e., over/underweight, dehydration, edema, cracked lips, pallor, dull dry hair, swollen or red tongue, and bleeding gums). Also, attempt to observe the resident during mealtime to determine ability to chew and swallow and the need for assistance and/or adaptive devices. Verify that the resident is receiving the assistance needed. If the surveyor observes any of the above problems, notable difficulties or lack of assistance, such observations should be compared with resident assessment and plan of care information. Further specification regarding a facility's dietary services is available in both the "Observation of Eating (Supervision of Resident Nutrition)" and the "Dietary Services - Record Review Guidelines" section of the guidelines.

INTERVIEW

B. Interview Guidelines

The surveyor should determine if residents have any general complaints regarding meals (e.g., taste, temperature, consistency). Questions should also be asked about substitutions and snacks. In addition, the surveyor should ask residents if they are aware of their own special dietary needs. This line of questioning also permits residents to relate whether or not adjustments have been attempted when they expressed dislikes or desires to alter such special diets.

Suggested questions might be:

1. What type of diet do you receive? Do you know whether any foods or portions are restricted on your diet? If so, what are they?

2. Do you receive foods that are not appropriate for your diet? If so, what do you and the staff do about that?

3. What time do you receive breakfast, lunch, and dinner? Do you receive your meals on time? Do you always receive a meal at mealtime? If not, why? What happens then?

4. Do you like the taste of the food?

5. Is the temperature appropriate (i.e., ice cream cold, milk chilled, coffee hot, etc.)?

6. Do you get enough to eat? What do you do if you're still hungry after a meal?

7. Does anyone come from the kitchen to find out your feelings and opinions on the dietary service, your food portions, etc.?

8. Where do you eat (i.e., dining room, your room, etc.)? Is this your choice? Do you have a choice of where you eat?

9. Do you receive snacks in the evening? Do you have a choice about what you want to eat?

RECORD REVIEW

Dietary Services -- Record Review Guidelines

A. Assessment

Each resident must receive a nutritional assessment addressing the resident's status, problems, and capabilities. Documentation on the resident's assessment should include the following:

- Dietary allergies/sensitivities, ability to chew and swallow regular foods without difficulty.
- Mental and emotional condition.
- Physical appearance, skin condition, height, and weight.
- Appetite and food preference.
- Vitamin and mineral supplements.
- Food and fluid intake in measurable terms and frequency of meals.
- Degree of assistance needed in eating, related mobility, vision, or other identified problems.
- Medications (e.g., diuretics, insulin, antibiotics, etc.)
- Related laboratory findings (e.g., fasting blood sugar, cholesterol, sodium, potassium, hemoglobin, BUN).

B. Plan of Care

Each resident in the sample should have a nutritional treatment plan. The plan should demonstrate an awareness of care plans of other services to prevent conflicts. Realistic and measurable dietary goals should be established for each resident in accordance with identified problems. The plan of intervention should be directed at achieving these goals and should include the following documentation:

- Physician diet orders.
- Nursing plans for feeding and assistance at mealtime.
- Rehabilitative use of assistive devices, if appropriate.
- Frequency of meals.
- Modification of consistency of meals if resident has a problem or change in condition.
- Between meal and bedtime feedings.
- Socialization at meals.
- Social work/counseling of resident and family as needed (related to diet).
- Ideal body weight.

C. Intervention
The surveyor should look for:

- Evidence that the plan is being carried out (e.g., documentation in the resident's chart, observation by the surveyor, and resident/staff interviews). If the resident refuses treatment or does not respond to intervention, the notes in the chart should indicate efforts to intervene or provide counseling.
- Evidence that the resident's progress is regularly observed (e.g., awareness of food and fluid intake such as acceptance of foods, food consumed, and resident's appetite).
- Intake for resident on force fluids with fever, Foley catheter, problem feeders.
- Use of self-help devices.
- General evidence as to whether poor resident conditions are due to poor care or whether the facility has taken appropriate measures to prevent or resolve problems.

D. Evaluation/Reevaluation
Dietary notes should indicate progress toward desired outcomes. Evidence of reevaluation of the dietary plans should be available when goals are not being reached within specified time frames.

DIETARY SERVICES
SELECTED NUTRITIONAL REQUIREMENT
RECORD REVIEW

1. Anthropometry - Weight

- o Important indicator of nutritional outcomes.
- o Disease state can have adverse effect on desired body weight.

2. Weight for Height Calculation

Frame Size	Females	Males
Medium	Allow 100 lbs. for first 5 ft. of height* plus 5 lbs. for each additional. inch.	Allow 106 lbs. for first 5 ft. of height plus 6 lbs. for each additional inch.
Small	Subtract 10%	Subtract 10%
Large	Add 10%	Add 10%

*For heights under 5 ft. it is suggested that 2 1/2 lbs. be deducted for each inch under 5 ft.

Target Weight Ranges

Female

Height	Small	Medium	Large
4'6"	71 - 81	80 - 90	88 - 98
4'7"	73 - 83	82 - 92	91 - 101
4'8"	76 - 86	85 - 95	94 - 104
4'9"	78 - 88	87 - 97	96 - 106
4'10"	80 - 90	90 - 100	99 - 109
4'11"	82 - 92	92 - 102	102 - 112
5'0"	80 - 100	90 - 110	100 - 120
5'1"	85 - 105	95 - 115	105 - 125
5'2"	89 - 109	100 - 120	111 - 131
5'3"	94 - 114	105 - 125	116 - 136
5'4"	98 - 118	110 - 130	122 - 142
5'5"	103 - 123	115 - 135	127 - 147
5'6"	107 - 127	120 - 140	133 - 153
5'7"	112 - 132	125 - 145	138 - 158
5'8"	116 - 136	130 - 150	144 - 164

Male

5'3"	102 - 122	114 - 134	126 - 146
5'4"	107 - 127	120 - 140	133 - 153
5'5"	112 - 132	126 - 146	140 - 160
5'6"	118 - 138	132 - 152	146 - 166
5'7"	123 - 143	138 - 158	153 - 173
5'8"	129 - 149	144 - 164	159 - 179
5'9"	134 - 154	150 - 170	166 - 186
5'10"	139 - 159	156 - 176	173 - 193
5'11"	145 - 165	162 - 182	179 - 199
6'0"	150 - 170	168 - 188	186 - 206
6'1"	156 - 176	174 - 194	192 - 212

Amputation	% of Body Weight
Leg	20%
Below Knees	10%
Arm	6%

Suggested Standards for Evaluating Significance of Weight Loss

% of body weight loss

Interval	Significant Loss	Severe Loss
1 week	1-2%	2%
1 month	5%	5%
3 months	7-1/2%	7-1/2%
6 months	10%	10%

From Blackburn, et. al: "Nutritional and Metabolic Assessment of the Hospitalized Patient" JPEN bol. 1, 1977.

Lab Indices for Visceral Proteins

	Mild Deficiency	Moderate Deficiency	Severe
Albumin g/dl	<3.5-3.2	<3.2-2.8	<2.8
Total Lymphocyte Count (cu/mm)	<1800-1500	<1500-900	<900
Transferrin	<200-180	<180-160	<160

Estimating Caloric Needs

1. Determine basal caloric needs.

    -- Multiply desirable body weight (in pounds) by 10

2. Add activity calories.

    IBW x 3 for sedentary* (typing, ironing)
    IBW x 5 for moderate (scrubbing floors)
    IBW x 10 for strenuous (chopping down tree)

3. Adjust calorie level for weight increase or decrease

*Most institutionalized elderly will fall into the sedentary category or lower. May wish to use IBW x 1 or 2 for non-ambulatory patients.

Estimating Protein Needs

1. Allow 1 gram protein per kilogram of ideal body weight.

2. Increase to 1.2 - 1.5 gm/kg for patients with depleted protein stores (decubiti, draining wounds, long-bone fractures, etc.).

Evaluate Menu for Nutritional Adequacy

1. Milk and milk products -- 2 or more servings per day

2. Meat -- 2 or more (6 oz. per day)

3. Bread and cereal -- 4 or more servings per day

4. Fruits and vegetables -- 4 or more servings per day

Fluid Requirement

Based on actual body weight:

Over 55 years with no major cardial or renal diseases:
30 cc/kg/day

(NOTE: 2.2 lbs. equals 1 kg of body weight)

Example: 120 lbs / 2.2 lbs. = 54.5 kg (55 kgs)
55 kg x 30 cc - 1,650 cc/day

NURSING SERVICES
DIETARY SERVICES
TUBE FEEDING
OBSERVATION

A. Observation Guidelines

The surveyor should verify that the feeding is a nutritionally complete formula and is given in sufficient quantity to assure adequate nutrition. The surveyor should also determine the ratio of residents on tube feedings and attempt to verify that all tube feedings are medically necessary. Unless medically contraindicated, the facility should attempt to discontinue tube feedings and feed the resident by mouth.

The surveyor should also attempt to observe that:

- o Staff use proper technique in administering feedings and medications. Check to see that staff checks for location of tube before feeding and that tubing is irrigated before and after addition of medication.
- o N/G tubes are removed as ordered, or as needed, but usually weekly if made of poly vinylchloride (PVC). The newer premium tubes do not require such frequency changes. There are tubes made of materials that do not harden in the presence of gastric juices, such C-Flex, silicone rubber, or polyurethane.
- o The tube is clean and formula flows freely.
- o The equipment is clean and protected. If dressings are ordered, they are in place, clean, and dry.
- o The nasal tube is securely but comfortably secured on the face with skin maintained intact and without irritation.
- o The skin around the gastrostomy is kept clean and free from irritation or infection. It should be checked carefully for leakage of gastric contents.
- o A resident who has a N/G tube for a prolonged period of time should be observed for possible complications, such as nasal erosion, sinusitis, esophagitis, gastric ulceration, and pulmonary infection.
- o Residents who tend to vomit are fed slowly with head elevated.
- o Supplies for mouth care are in evidence, observe if possible for technique, mouth shows evidence of good care (i.e., moist, clean).

- Formula or milk preparations are kept at room temperature no longer than two (2) hours. Commercially prepared products should hang no longer than four (4) hours. Food gavage is kept at room temperature no longer than one (1) hour.

- Milk base, facility make formulas are made daily. All left over formula is discarded.

INTERVIEW

B. Interviewing Guidelines

The surveyor should interview staff regarding their knowledge of the feeding schedule and training in administering tube feedings. Some residents having difficulty in speaking or swallowing with the tube in place(i.e., poor toleration). The surveyor should inquire if mouth feeding was attempted.

If the resident is able to be interviewed, suggested questions may be:

1. How long have you been fed by this tube?

2. When was the last time you tried to eat by mouth? What happened?

3. How often do you receive the feeding? Is this consistent? Who does the feeding? Do you feel comfortable/safe with all staff who perform the feeding? If not, what happens?

4. Do you have problems with vomiting, diarrhea, or constipation? What does the staff do when this happens?

5. Are you losing or gaining weight? What is your goal?

6. How often is the tube changed? Who does this? Do you feel comfortable/safe with all staff who perform this procedure?

RECORD REVIEW

Tube Feeding -- Record Review Guidelines

The feeding should be a nutritionally complete formula and should be given in sufficient quantity to assure adequate nutrition. The surveyor should assure that there is a physician's order for the nasogastric tube (N/G) or gastrostomy tube specifying kind, frequency, and amount and number of calories as well as amount of additional water and that the orders are being followed. Documentation should be present regarding removal and reinsertion of tubes. The record should indicate that measures have been taken to prevent diarrhea and constipation and to treat them if they have developed.

A. **Assessment**

The assessment should address:

- Need for a nasogastric or gastrostomy tube feeding, particularly medical documentation by a physician.
- Any problems or limitations as a result of the tube feeding.
- The adequacy of formula, as ordered, to caloric and protein needs of the resident.

B. **Plan of Care**

The plan of care should clearly address:

- The kind, frequency, and amount of feeding based on the physician's orders, and the time span over which each feeding is accomplished.
- Specific goals to overcome or improve the problem(s) identified.
- Methods to accomplish the goal (observation, supervision, training).
- Services necessary and who will perform the services.

C. **Intervention**

- Tube feeding is nutritionally adequate.
- Attempts have been made to discontinue tube feeding if indicated.
- Skin is free from irritation; mouth care is given at least three (3) times daily.
- Changes in resident condition are noted and addressed (weight loss, constipation, diarrhea, skin condition).
- Observed problems are coordinated with other departments and resolved.
- Check that feeding is occurring at the ordered/appropriate rate.

D. **Evaluation/Reevaluation**

Notes should indicate progress, deterioration, or the development of new problems. Measures are taken to prevent diarrhea or constipation and to treat them if they develop.

Goals should be modified, if necessary, based on progress or lack of progress in meeting goal(s) or a change in the resident's condition.

REHAB NURSING AND REHABILITATION SERVICES OBSERVATION

A. Observation Guidelines

The surveyor should attempt to determine that residents are functioning at their optimal physical level, are free from preventable musculo-skeletal pain, and are receiving rehabilitative services as their condition warrants. Specific observations to be made in this area include:

- Treatments being given are those specified in the plan of care and address individual resident needs.
- Assistive devices are being provided as needed, the devices fit well, function, and are used properly (e.g., wheelchairs, crutches, braces, glasses, hearing aids, canes, artificial limbs, assistive eating devices.).
- Other equipment is clean, functioning properly, periodically inspected and maintained, and available in sufficient quantity for resident needs. If possible, observe the equipment in use.
- The therapy room is sufficiently large to treat residents, accessible to residents, and adequately supervised by appropriate staff.
- Proper techniques are used in therapy treatments performed between therapists' visits (e.g., range of motion, transfers, ambulation).
- Residents with amputations have independent prosthetic management.
- Nonverbal residents are provided with means of communication (e.g., writing tablets and utensils, picture cards).
- Visually impaired residents have no impediment to ambulation and are provided with magnifiers, large print books as applicable.
- In general, residents are not isolated as a result of limitations.
- Residents with contractures are made as comfortable as possible and measures are taken to prevent or retard deterioration.

INTERVIEW

B. Interview Guidelines

Resident interviewing is intended to assist the surveyor in understanding the resident's perception of the treatments he/she is receiving, the value of the treatments, and the extent to which the plan of care is being followed. All data gained through resident interviews should be verified when reviewing the medical record and interviewing staff.

The surveyor should also interview staff members to ascertain:

- That they are aware of their responsibilities and job descriptions.
- That they are aware of the plan of care requirements for individual residents and their role in meeting these requirements.
- That the requirements are being carried out as ordered.

Suggested questions for residents might be:

1. Are you receiving P.T/O.T/Speech therapy at the current time? If so, for what reason? How often? Is this consistent? What are your goals? Do you have input into your plan of care? Are your goals included in your plan of care? Does the nursing department or anyone else encourage you, practice with you, or follow through on therapy instructions? Do you feel nursing and the therapy department is communicating?
2. Do you feel you're in need of therapy service but not receiving it? If so, what type? What have you done about this?
3. If the resident has an assistive or prosthetic device, how long have you had the device? Were you trained in its use/operation? Does it meet your needs? Does staff know what to do with it? If you have problems, what do you do? What is staff response to problems?

RECORD REVIEW

Rehabilitation Services -- Record Review Guidelines

Surveyors should review the medical records to identify physician orders for rehabilitative services, rehabilitative plans of care, and resident progress through rehabilitative progress notes. Determine if the therapist has outlined regular therapy regimens as needed (for example, to prevent contractures), that staff follows such regimens, and that other departments (especially nursing) cooperate and coordinate as necessary.

A. Assessment

The information provided for each resident should clearly describe the need for rehabilitative services including:

- Resident history.
- Impairment record (status of skin, extremities, sensory/communication system, bowel and bladder, etc.)
- Functional limitations.
- Rehabilitative potential.
- Precautions.

B. Plan of Care

These plans should be individualized and physician approved, and should directly relate treatments with identified problems. Determine that each intervention plan:

- Identifies specific rehabilitative needs and objectives.
- Identifies treatment necessary to meet specific measurable rehabilitative goals.
- Identifies type, amount, frequency, and duration of treatment.
- Identifies modalities and person who will perform the treatment.

C. Intervention

The surveyor should attempt to verify that:

- Rehabilitative service progress notes are written, generally weekly, and that they reflect the resident's response to treatment.
- The progress notes contain the treatment and dates given, an evaluation of resident progress, and the signature of the person providing the service.
- The resident's progress is communicated to the resident's physician and all involved staff.
- There is evidence in the progress notes and the resident's care plan that the plan of care has been modified, if necessary, based on progress, lack of progress, or change in condition.

- Discharge plans include instructions to the resident and plans for continued care by staff and/or family, if applicable.

D. **Evaluation/Reevaluation**

The surveyor should locate and review:

- Notes indicating if rehabilitative goals have been met.
- Notes indicating resident has not met goals, has reached a maintenance level, or has made improvement.
- Notes indicating reevaluation of resident, if goals in initial plan have not been met within the specified time frame.
- Notes indicating review and revision as necessary but at least quarterly.

SOCIAL SERVICE OBSERVATION

A. Observation Guidelines

The surveyor should verify that observed behavior problems are recorded by facility staff and taken into consideration in social service plan of care. Mental status should be considered a determinate of resident behavior. For example, a resident who is chronically confused and does not interact requires a different care plan than a resident who is not confused and does not interact.

Following is a list of observable behaviors which can aid in classifying residents with behavioral problems that may require social services. It is important to remember that residents may exhibit one or several of these behaviors:

- Disoriented
  - Cannot consistently locate room
  - Does not know own name
  - Does not know place
  - Does now know day/time

- Confused
  - Misinterprets surroundings
  - Responds inappropriately to questions
  - Is delusional, living in fantasy world
  - Does not appear to recognize staff/family
  - Makes inaccurate statements about events and surroundings

- Uncooperative, Disruptive, Aggressive
  - Refuses to cooperate with staff in accepting care or suggestions, etc.
  - Is verbally abusive
  - Gives abrupt or unfriendly answers when spoken to
  - Hits or bites without provocation
  - Interferes with other residents and/or staff

- Anxious
  - Wrings hands, has worried expression
  - Acts agitated, paces floor, can't sit still
  - Picks at clothes, speaks rapidly and compulsively

- Withdrawn, Isolated
  - Is nonresponsive to others
  - Is tearful
  - Has sad expression on face (flat affect)

- Lonely
  - Calls to anyone passing door

-- Does not want anyone to leave room
-- Grabs hand and refuses to let go

Vision and hearing problems are also observable conditions which can require social service intervention.

INTERVIEW

B. Interview Guidelines

The goal of resident interviewing should focus on the identification of:

- o Concrete problems which have resulted from placement, such as obtaining Medicaid eligibility, community services, liaison to other agencies, obtaining glasses.
- o Adjustment to disease, disability, and placement.

Each resident s self-reported problems and adjustment can then be noted for evaluation during the examination of the record.

It is important that surveyors ask residents who are oriented about their behavior if that behavior is inappropriate. In this manner their response can be checked with the problem list, care plans, and intervention in the record.

All self reports must be validated in the record review process. Inaccurate resident self reporting about the degree to which they understand any disease, disabling condition, or problems of their placement are helpful in determining if facility personnel have documented and evaluated similar inaccurate self reports. Unless it is clear that the resident's mental status inhibits accurate self reports, social services should be involved in addressing the reasons for these distortions.

Since questions regarding social service needs are closely related to resident rights, it is appropriate to expand this part of the interview into that area. Suggested questions might be:

1. What kind of problems have you had since you came to this facility?

2. Who helped you with them?

3. When you have a personal problem to whom do you tell it?

4. Do you have any family? Do they have any problems getting to visit you?

5. Have you had any problems with which this facility has not been helpful?

6. If the resident is disruptive, depressed, agitated, anxious, etc. -- I noticed that you are upset (quiet, nervous, unhappy) today. Can you tell me what has bothered you?

7. Do you make use of the dining, activity, community room, and/or outdoor areas?

RECORD REVIEW

Social Service -- Record Review Guidelines

Concrete problems which result from placement and resident adjustment following admission to a long term care facility must be evaluated by a social worker or consultant. Often times, as a result of placement, residents can appear much less oriented and capable besides exhibiting behavior problems. The cause of these symptoms is often the hopelessness and depression which results from loss of control over one's affairs and not organic deterioration. To lessen these difficulties and maintain or improve resident's level of functioning, their strengths and weaknesses must be evaluated and addressed in a complete resident care plan.

It is crucial that social service plans demonstrate an awareness of resident conditions and diagnoses since some conditions will automatically warrant social service input. For example, vision, hearing, and psychiatric conditions should be routinely evaluated in the social service assessment. Social service personnel should specifically note when no intervention is required for these problems.

Also, social service personnel should not just demonstrate awareness of behavior. They must attempt to articulate the reasons for it and indicate in the plan of care an approach to the behavior. For example, residents who are uncooperative may not be just provocative personalities but perhaps genuinely depressed as a result of their disability or concerned about concrete problems which have resulted from placement, such as the management of their household, pet, or financial affairs.

A. Assessment

Specific plans and methods which will be used to address each specific problem should be noted in the social services assessment. Assessments should demonstrate a flexible approach to each resident. For example, a good assessment will result in a clear understanding of which residents adjust better through group activities and which require individual intervention. Services which reflect a singular approach to all residents are generally lacking in the overall ability to meet needs of all types of residents.

o Mental Status Evaluation

This evaluation need not be performed by social service personnel, however, they should demonstrate awareness of the mental status evaluation. The evaluation should include:

- Orientation to time, person, place, and situation.
- Mood.
- Memory.
- Behavior.
- Ability to communicate and level of accuracy of resident self reports.

o Resident History

Historical information should communicate accurately and salient features of a resident's life, personality, and overall adjustment including:

- Information about family, marriages, children, current relationships, other significant persons, occupational history and religious affiliation, practices, and needs, plus recreational interests.
- For residents with psychiatric conditions, history of present problems with appropriate information from other resources regarding treatment and/or previous psychiatric admissions.
- For residents with chronic confusion, description of resident behavior related to this problem.
- For residents with vision or hearing loss, information regarding resident adjustment to the condition if not improvable.
- For residents exhibiting social isolation, information as to previous lifestyle and social interaction patterns.

o Family Availability for Planning, Resident Support, Etc.

- Spouse.
- Children.
- Significant others.

o Identification of Concrete Problems Resulting From Placement

    - Special funding.
    - Special devices.
    - Contacts with others regarding special problems resulting from placement.
    - Transfer agreements.

- Recent Social Adjustment
    - Behavior prior to placement.
    - Companionship needs and relationships.
    - Resident concerns about concrete problems.
    - Response to illness, disability, and/or placement.
    - Deterioration in previous adjustment as reflected by increase in physical symptoms, depression, and behavior problems.

- Discharge Planning
    - Awareness of physician and nursing assessment of resident's potential discharge.
    - Evidence of active involvement of resident, family, or others in plans necessary to effect discharge.
    - Social isolation: plan discusses availability and assistance of family, friends, etc.
    - Awareness of community resources that may be needed.

B. Plan of Care

Each plan of care should demonstrate awareness of the resident's diseases and disabilities plus the care plans from other services such as nursing, dietary, and activities as well as the physician. It should include goals for satisfaction of concrete problems within specified time frames. Finally, it should include adjustment goals within specified time frames.

- Plan for Concrete Social Services
    - Application for special funding.
    - Request for special devices.

- Contacts with family members, agencies, or other persons.
- Transfer arrangements.

o Plan for Supportive Services Necessary for Adjustment

- Plan for behavioral management if necessary.
- Need for psychiatric consultation.
- Ongoing supportive contacts with family.
- Ongoing involvement in resident activities focused on adjustment.
- Consultation to staff on handling problems or needs.

o Adjustment Goals

- Able to be characterized as maintaining, delaying, regaining, or preventing.
- Include specific time frames and milestones.

o Interventions for Specific Conditions

- Psychiatric condition: interventions aimed at involving residents in community resources; also specific interventions for identified behavioral problems.
- Chronic confusion: plan for behavioral management based on reality orientation, sensory stimulation.
- Vision/hearing loss: plan of intervention including use of community resources in procuring appropriate assistive devices.
- Social isolation: plan discusses availability and assistance of family, friends, etc.

C. Intervention

The surveyor should look for:

o Evidence that social service care plans are actually being carried out as specified for each identified problem.

o Evidence of evaluation of resident's adjustment at periodic intervals. This should include noting resident's affect, mood, behavior, concerns, complaints, etc.

- Evidence of weekly contact with resident and/or family for first two months and on an as needed basis thereafter.

- Consultation to staff as needed.

D. **Evaluation/Reevaluation**

Social service notes should indicate the satisfaction of each concrete need identified in the assessment. For example, this ranges from securing necessary application forms for special community services and checking on an application following submission to the notation for satisfaction of the request. It can also relate to location of transportation service for the spouse of a resident, obtaining eyeglasses, hearing aids, etc.

Social services directed at adjustment should address whether or not the goal of maintaining, regaining, preventing, or delaying an adjustment reaction to a specific condition or placement has been reached. If it has not been reached over a specified time frame, evidence of reevaluation and readjustment of the plan should be present.

Residents often have problems which require social services activity well after their admission and initial assessment. For this reason, social service should demonstrate periodic evaluation of each resident. Also, it is important that social services demonstrates that it is part of a multidisciplinary team. Records will indicate the degree of problem referral and communication which social services has achieved within the facility. Referrals or requests for services need not be formal. However, social services should document the referral source and indicate its assessment and plan. This indicates that social services is providing continuous input to other personnel on the resident's behalf. Other indicators include:

- Evidence that residents are evaluated by social services on a periodic basis.

- Evidence that behavior, changes in condition, new problems, etc., as well as any other problems noted by other services are addressed by social services on an ongoing basis.

- Evidence that plans and their interventions are evaluated and readjusted when the desired outcomes do not result.

ACTIVITIES

OBSERVATION

A. Observation Guidelines

All residents should be involved in activities. This means that residents with all types of loss of function should be involved in an activities program unless it is directly contraindicated by their condition or their physician. Residents who are ambulatory and alert are most likely to participate in activities and/or exercise choice in attendance. Residents with problems in vision, hearing, coordination, orientation, and ambulation or dependency in four or more areas of ADL should be more carefully evaluated. Effective activities programming for these residents will require more personal assistance and activities adaptation but will aid the overall management of the resident. For example, activities may aid in identifying the actual level of confusion of some residents by reducing resident isolation and by providing sensory stimulation.

Overall resident activities should be aimed at creating a supportive living environment that promotes independence and meets each resident's activity needs. It is important to remember that activities programming must have all residents in focus. Therefore, each resident should be evaluated shortly after admission and then at periodic intervals as the resident adjusts to placement. The first reevaluation should be performed after a reasonable period of adjustment usually thirty days after admission.

An effective activity program will be multi-faceted as it attempts to meet needs of all residents, each of whom has a differing level of functional ability. The program should have individual as well as group activities and evening as well as daytime activities. The program should attempt to address the following aspects of resident life:

- Social aspects: activities to reduce self-consciousness, increase self-confidence, stimulate participation and interaction.
- Creative aspects: activities which emphasize individual accomplishment and skill discovery.
- Work and service aspects: activities to increase self-esteem and independence through monetary rewards or satisfaction of helping another person or the community.
- Intellectual aspects: activities emphasizing thinking, problem solving.
- Physical aspects: activity to improve physical condition, exercise muscles, and increase coordination.

- Spiritual or religious aspects: activities to reinforce residents' religious convictions or personal peace of mind.

The surveyor should observe activities while in progress in order to complete the in-depth review. The surveyor should also observe individual resident rooms for personal affects/quality of life items as well as the availability of materials in resident rooms and on units for meaningful activity. These observations can help the surveyor to determine how the resident occupies his/her time.

INTERVIEW

B. Interview Guidelines

Residents should be interviewed in order to determine the frequency and types of activities with which they are familiar. While alert and ambulatory residents should be able to provide information about potential and/or actual level of their participation, other alert residents who are not ambulatory can provide information about how well activities programming meets their special needs. These self reports should be validated during record review.

Suggested questions might be:

1. How do you spend your day?
2. Do you go to activities? If not, why not?
3. How are you made aware of upcoming/daily programs or happenings?
4. Of the activities you attend, what do you like most/least? What activities would you like to see more of/less of? Does anyone come around and get your opinion about the activities?
5. Do you attend Resident Council? If so, does the Resident Council address these issues?
6. Do you have problems getting to activities? If so, does the staff help? Does staff encourage you to go?
7. Do you ever go out of the facility?
8. Do you feel between going out and people coming in that you are part of the community?

RECORD REVIEW

Activities -- Record Review Guidelines

A. Assessment

The following areas should be addressed in an individual assessment by the activities coordinator.

- Mental Status Evaluation

  Although this evaluation need not be performed by activities personnel, they should demonstrate awareness of the resident's intellectual and emotional state including:

  - Attention span, memory.
  - Orientation to time, person, place, and situation.
  - Ability to communicate and level of accuracy of resident self reports.

- Social History

  - Activities personnel should demonstrate awareness of the resident's history as documented by social services.

- Medical Problems

  - Such as allergies or dietary restrictions which may limit some activities.

- Physical Functioning

  - Awareness of exercise level, range of motion, and coordination.
  - Awareness of ADL performance.

- Adjustment to Placement

  - Including both adaptive and maladaptive behaviors.

- Resident Interests

  - Including self report, family, and staff perceptions.

B. Plan of Care

The plan of care should demonstrate a flexible approach to all residents. For example, all residents may need a period of adjustment just after admission. During this time, individual activities may be utilized to facilitate adjustment. However, if all residents continue to receive only individual activities, then activities personnel may not be sensitive to adjustments residents make after their initial placement.

At the same time, if group activities are the only form of activities, then the activities personnel may not be making any attempt to make individual contact with residents to identify their needs. The plan should also demonstrate an awareness of care plans from other services. This includes P.T., O.T., and speech therapy, as well as nursing, dietary, and social services. Goals should be specified for the new resident. These should have a specific time frame. Thereafter, goals should be periodically reformulated. Goals should relate specific aspects of an activity program to individual resident needs. For example:

- Resident Needs Sensory Stimulation

    -- Goals: identify ten (10) items and texture by touch daily with activity staff.

- Resident Needs Supportive Encouragement

    -- Nursing and activity staff each day praise resident for each ADL completed independently by 10:00 a.m.

Activity plans should clearly reflect the methods which will be utilized to assist residents with ADLs and other self-care skills and should include the following elements:

- Method to facilitate adjustment.
- Method to establish and maintain the continuous involvement of the resident.
- Individual activities and group activities.
- Able to be characterized as maintaining, regaining, delaying, or preventing.

C. Intervention

Surveyors should look for:

- Evidence that activity care plans have been carried out through documentation of both frequency (individual/group) and time.
- Evidence of evaluation of resident's adjustment at admission and at approximately 30 days after admission.

D. Evaluation/Reevaluation

Activities personnel should document the degree to which each goal has been met. This is especially true for the new resident. In this manner, the movement from initial types of activities to more typical activities can be observed. Evaluation should include:

- Evidence that residents are evaluated by activities personnel on a periodic basis, with emphasis on resident participation levels and readiness for new activities.
- Evidence that changes in condition and new problems, as well as any information related by other staff, are addressed by activities staff on an ongoing basis.
- Evidence that plans and their interventions are evaluated and readjusted when desired outcomes do not result.

RESIDENT RIGHTS

OBSERVATION

A. Observation Guidelines

The evaluation of a facility's ability to assure protection of resident rights begins with observations which are conducted at the initiation of the tour. However, observations for resident rights as with other areas of survey should be conducted throughout the survey. These observations should focus on the treatment which residents receive. The treatment should be evaluated in terms of staff consideration of each resident's individual needs. Treatment should be courteous and respectful. Additionally, the privacy of treatments, toileting, bathing, and other activities should be maintained. Observations of residents in the in-depth sample whose care and treatment is not private should be noted under Grooming and Personal Hygiene on the Observation/Interview Outcome Checklist. However, patterns of care which reflect a lack of respect for rights should be noted, observed, and specifically identified as noncompliant as specified in the section regarding Review of Additional Records.

INTERVIEW

B. Interview Guidelines

Interview information about resident rights is crucial to assuring that a facility protects these rights. Since some information about the ability of residents to exercise their rights can only be obtained from interviews with residents themselves, it is crucial that surveyors attempt to obtain information in a consistent manner from a number of residents so that patterns can be established. Interview questions in these areas should initially be phrased as "When a person in this facility..." rather than "Do you...", since residents may be more comfortable responding in the first instance. However, when a resident does indicate that a problem exists, the surveyor should ask "Has this ever happened to you?" In some instances questions about procedures and care as noted in other sections for review will indicate a resident's lack of information about his/her condition. Frequently, this will require use of questions relating to the resident's knowledge about care which reveal that no attempt has been made to inform him/her about his/her condition.
Suggested questions might be:

1. Are residents safe in this nursing home?

2. Do residents in this facility have problems with lost money/personal belongings?

3. Are staff kind and considerate to residents?

4. Does the facility seem responsive to resident rights (i.e., obtain your opinions, etc.)?

5. Are residents able to bring in personal belongings? Are they encouraged to do so?

6. Do you belong to Resident Council? Is Resident Council encouraged by administration? Is administration responsive to Resident Council?

7. Are residents able to wear their own clothing consistently? Does clothing return from laundry promptly? In the same condition it went to the laundry?

8. Can residents manage their personal affairs if they so choose and are able?

9. Does mail arrive at resident rooms unopened?

10. Do residents have enough privacy?

RECORD REVIEW

Resident Rights -- Record Review Guidelines

Record review should begin with determination that residents have been informed about their rights and of all rules and regulations governing resident conduct and responsibilities. Residents who have not been informed about their condition should have a physician's statement indicating that this is contraindicated.

Additional record review for resident rights should be conducted when problems have been identified through interviews. The surveyor should examine records to determine if any more data is present which could illuminate the area in question. For example, the surveyor might attempt to discern whether a pattern of unresolved complaints relating to a specific resident rights issue (or issues) can be identified in the facility using such sources as the individual resident record, minutes of Resident Council meetings, accident/incident reports, etc.

Record review should also determine that resident families/significant others are notified in the event of an accident, or other significant change in physical, mental, emotional status, or resident charges, billings, and related administrative matters.

During record review the surveyor can ascertain that it is documented that the resident is consulted (or if incompetent, the next of kin or legal guardian) when facility is transferring, changing rooms, discharging, or if treatment changes radically (except in emergency).

PHARMACEUTICAL SERVICES
RECORD REVIEW
Record Review Guidelines

In assessing the adequacy of a facility's performance of drug regimen reviews, surveyors should base their judgement on the following indicators:

- Reviews should be performed in the facility (not a regulatory requirement).
- The number of reviews performed in the last month are equal to the resident census in that month.
- The average prescription utilization is not substantially over 6.1.
- The number of drug irregularities identified by the pharmacist or nurse reviewer is at least 5 per 100 resident months.
- Apparent irregularities are identified by the pharmacist or nurse reviewer and documented.
- An individual with authority to correct apparent irregularities in drug therapy (e.g. physician) is notified of such irregularities by the pharmacist or nurse reviewer.
- The assessment should cover at least six drugs.
- Does the pharmaceutical review entail such issues as meds ordered by M.D., stop dates, all that basic type of thing?

(NOTE: Appendix N, Part I of the State Operations Manual, entitled "Indicators for Surveyor Assessment of the Performance of Drug Regimen Reviews", offers additional detailed instructions in this regard).

PHYSICIAN SERVICES
RECORD REVIEW
Record Review Guidelines

A. **Assessment**

The surveyor should verify that each resident has a medical evaluation based on a physical examination performed within 48 hours of admission or no more than five days prior to admission. Other information which should be readily available includes:

- A current diagnosis, available prior to or at admission.
- A medical history and an indication of rehabilitation potential, available within 48 hours of admission.

In intermediate care facilities the assessment requirement is an initial examination and periodic re-examination.

B. Plan of Care

The surveyor should verify that physician orders for each resident are available prior to or at admission and address all medical conditions and needs including diagnosis and orders for immediate care. The orders should cover:

- Medications and treatments.
- Diet.
- Therapies (P.T., O.T., Speech).
- Activities (bedrest, ambulatory, able to participate).

In both skilled nursing and intermediate care facilities, documentation should show that the resident's plan of care is in conformance with the physician's orders.

C. Intervention

The surveyor should determine that physician services include the following:

- Physician is available in emergencies.
- Physician visits resident at minimum required intervals.
- Physician progress notes are timely (every visit or every 30 days).

READEX FICHE

D. **Evaluation/Reevaluation**

The surveyor should determine that each resident's condition is evaluated as required including medications and treatments.

- o For skilled nursing facilities, physician orders should be reviewed and updated at least every 30 days for the first 90 days and then reviewed no less than every 60 days thereafter and revised as necessary.
- o For intermediate care facilities, there should be progress notes indicating that a physician has seen each resident at least once every 60 days.

Alternate physician visit schedules that exceed a 30 day schedule are justified by the physician in the medical record. These visits cannot exceed 60 days or apply to residents who require specialized rehab services. (EXCEPTION: ICF residents must be seen every 60 days unless otherwise justified and documented by the attending physician.)

Progress notes are written and signed by the physician at the time of each visit.

OTHER

RECORD REVIEW

1. The facility notifies the resident's attending physician in the event of a change in condition. This area is well covered under the specific areas for review (i.e., skin, respiratory, etc.) however, it is included here also.

2. Laboratory and Radiologic Services.
   All services are provided only on the order of a physician. The physician is promptly notified of diagnostic findings. Signed and dated reports of a clinical laboratory, x-ray, and other diagnostic services are filed with the resident's medical record.

PHARMACY RECORD REVIEW SUMMARY (Use ONLY For Residents In Indepth Sample)

APPARENT IRREGULARITIES: Evaluating SNF/ICF Drug Regimen Review

(NOTE: See Appendix N, Part 1 of the State Operations Manual for Details of Apparent Irregularities.)

OBSERVATION/ELEMENT	PATIENT IDENTIFIERS										SURVEYOR NOTES/COMMENTS
1. More than 1 drug order for the same drug (e.g. different routes or brands.)											
2. Drugs administered beyond stop order policies.											
3. PRNs given every day for more than 30 days											
4. 3 or more laxatives ordered concurrently (sequential orders not incl)											
5. Use of major tranquilizers or antidepressants for less than 3 days.											
6. Continuous hypnotic drug used more than 30 days											
7. Concomitant use of more than 1 hypnotic drug											
8. Hypnotics in excess of listed dosages.											
9. Concomitant use of more than 1 major tranquilizer											

OBSERVATION/ELEMENT	PATIENT IDENTIFIERS										SURVEYOR NOTES/COMMENTS
10. Major tranquilizer doses in excess of listing											
11. Anti-anxiety dosages more than those listed											
12. More than 2 changes of antidepressants in 7 days											
13. Antidepressants in excess of listed doses											
14. Repeated loss of seizure control while taking anticonvulsants											
15. Patients on thyroid without thyroid function tests											
16. Antihypertensives without blood pressure at least weekly											
17. Anticoagulants without clotting assessment at least every month											

OBSERVATION/ELEMENT	PATIENT IDENTIFIERS										SURVEYOR NOTES/COMMENTS
18. Cardioactive drugs without pulse taken for the first month and weekly thereafter or pulse consistently more than 100 or lower than 60.											
19. Insulin or oral hypoglycemics without daily urine sugar test or blood sugar test at least every 60 days.											
20. Iron, folic acid, or B-12 without red blood cells assessment first month of therapy.											
21. Mandelamine, Hiprex, Bactrim, Septra, Macrodantin, Furadantin or Urex without urinalysis at least once 30 days after start of therapy.											
22. Use of Mandelamine without urine pH within 30 days after start of therapy, or if pH continually above 6.											

OBSERVATION/ELEMENT	PATIENT IDENTIFIERS										SURVEYOR NOTES/COMMENTS
23. Nitrofurantoin (Furadantin, Macrodantin) use if: a) used for other than treatment or prevention of urinary tract infection; b) Blood urea nitrogen or serum creatinine levels not recorded in chart.											
24. More than 3 analgesics used at the same time.											
25. Diuretics without serum potassium within 30 days of start of therapy.											
26. Diuretics and cardiotonics together without serum potassium within 30 days of start and every 6 months thereafter.											
27. Use of butazolidin, azolid, or tandearil continuously for 30 days without complete blood count after start of therapy.											

OBSERVATION/ELEMENT	PATIENT IDENTIFIERS										SURVEYOR NOTES/COMMENTS
28. Use of cardiotonics without a diagnosis of CHF, atrial fibrillation, paroxysmal supraventricular tachycardia or atrial flutter											
29. Use of anticholinergic therapy with anti-psychotic drugs in the absence of recorded extra-pyramidal side effects.											
30. Continuous use of antibiotic/steroidal ophthalmic preparations that exceed 14 days.											
31. Use of aminoglycosides in the absence of serum creatinine determinations.											
32. Orders for drugs to which the patient has a known allergy.											
33. The crushing of solid dose forms that result in patient discomfort or undesired blood levels.											

TOUR EXERCISE

OBJECTIVES

Tour

At the completion of this session, each participant will be able to:

- Identify twenty-four examples of questionable patient care.
- List these examples in 9 categories on the Tour Notes Worksheet.
- Document deficiencies on the Survey Report Form.

IN-DEPTH INTEGRATED
TOUR EXERCISE
SKILLED NURSING FACILITY

October 23
9:00 a.m. to 11:00 a.m.

1. Title slide.
2. Nursing assistant in Room 142.
3. Resident #1623, Room 132.
4. Resident #1635.
5. Resident #1641.
6. Dirty utility room.
7. Resident #1629 sitting in main activity area.
8. Residents #1609, #1620, #1627, and #1633 in hallway during entire tour time between 9:00 a.m. and 11:00 a.m. Craft activity being offered elsewhere. Staff says these women are unable to participate.
9. Resident #1602.
10. Resident #1620 viewed from hallway.
11. Activity sewing area.
12. Utility room.
13. Back entryway.
14. Locked beauty shop.
15. Floor under kitchen sink.
16. Kitchen.

17. Kitchen.
18. Kitchen freezer.
19. Unlocked cupboard in unlocked activity area. Bottle label indicates poison.

ADDITIONAL TOUR FINDINGS

1. Resident #1621 has assistive device for dressing which broke 10 days ago. She states she reported it to staff and has received no word from staff regarding when it will be repaired.

2. Resident #1606 observed being ambulated by one nursing assistant in hallway wearing socks, without shoes.

3. Resident #1631 observed restrained in geri-chair for three hours without release. At the end of this time, resident had episode of urinary incontinence which prompted staff action.

4. During entire tour time all bedside water pitchers were noted to be present at bedside, but without water.

5. Staff members were observed to enter room of Resident #1611 without knocking on the door, gave no reason for being in the room, and did not close the door when they left.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

TOUR NOTES WORKSHEET

PROVIDER NUMBER

SURVEY DATE

INSTRUCTIONS

1. *Note care and problems in care on all units.*
2. *Report deficiencies directly to survey report form or evaluate further during indepth sample review.*
3. *Select residents for indepth review.*
4. *Select a proportionate number from each section.*

INDEPTH SAMPLE			
Facility Bed Size	*<60*	*60-200*	*200+*
Sample Size	*5*	*10%*	*30*

OBSERVE RESIDENTS FOR THE FOLLOWING CARE PROBLEMS

GROOMING/PERSONAL HYGIENE

POSITIONING

ASSISTIVE DEVICES

AMBULATION

RESTRAINTS

HYDRATION

INFECTION CONTROL

PATIENT RIGHTS

OTHER

FORM HCFA-521 (11-85)

FORMS UTILIZATION GUIDES

The forms utilized in the Federal method of survey were developed to be utilized in an inter-related fashion. The Survey Report Form shall be used for both skilled nursing facilities and intermediate care facilities. In dually certified facilities the skilled nursing regulations apply except when there is a question of care about a resident classified at the intermediate care level.

In skilled nursing facilities with an intermediate care distinct part, the SNF and ICF regulations apply.

The Federal Survey Packet Contents

Form	Number
Tour Notes	One (1) or more per surveyor
Residents Selected For In-depth Review	One (1) per surveyor and one for completed packet, dependent on sample size
Drug Pass Worksheet	Two (2) or more
Dining Area & Eating Assistance	One (1) per meal to be observed
Observation/Interview/ Record Review	One (1) per resident in sample
Survey Report Form (Includes Face Sheet - patient census)	One (1)
Deficiency Statements (Form #2567)	As needed

Usage of the Form

Form	Instructions
Face Sheet	-- Complete all areas with the assistance of the facility. -- Each total within the blocks of descriptive information regarding residents is to equal 100% of the resident census, except the block in the lower right hand corner of the second page. -- Submit with complete survey packet.
Tour Notes	-- Utilized by all surveyors in facility to maintain notes regarding resident findings at any time while in the facility. Physicial Environment findings need not be noted on this form. They may be documented directly on the Survey Report Form. -- Each surveyor transfers problems found to Survey Report Form under appropriate rule in column labeled "Explanatory Statements". -- Maintain in State office.
Residents Selected for In-Depth Review	-- Completed by surveyor(s) selecting sampled residents for in-depth review. Fill out name or identifier of resident and reason for selection. -- Maintain in State office.
Drug Pass Worksheet	-- Completed by surveyor while observing the drug pass observation. -- Findings transferred to survey report form under appropriate rule in column labeled "Explanatory Statements". -- Maintain in State office.
Dining Area & Eating Assistance	-- One form completed for each meal observed. -- Review each indicator listed. Note findings on right hand side of page. -- Transfer problematic findings to survey report form under appropriate rule in column labeled "Explanatory Statements". -- Maintain in State office.

Observation/Interview/ Record Review	-- Complete one for each resident identified for in-depth review. -- Complete the observation/interview section while observing and interviewing the resident. -- Under ADL Section, check box if assistance is needed. -- For the remaining sections, check if condition or problem exists. -- The record review portion is completed separately from the interview/observation time. Complete as the surveyor reconciles observation/interview findings with the record and the record against itself. -- Complete the observation/interview/record review on a resident-by-resident basis, drawing together a summary of problematic findings or conclusions, and noting that summary in the "Notes" section. -- Transfer negative findings and conclusions to survey report form under appropriate rule in column labeled "Explanatory Statements". All information regarding each resident need not be transferred. Instead the note may read "See OIRR for resident # re: poor catheter care." -- Maintain in State office.
Survey Report Form	-- Completed as surveyor(s) transfer problems from the following forms: - Tour Notes - Drug Pass Worksheet - Dining Area & Eating Assistance - Observation/Interview/Record Review Once data from all forms has been transferred, the surveyor(s) determines deficiencies as appropriate, indicating by marking the yes (met) or no (not met) or N/A, where the issue is not applicable. Rules indicated as not met are to be on HCFA 2567. -- Maintain in State office.
Deficiency Statements	-- Complete utilizing data gathered during survey and from survey report form.

DRUG PASS OBSERVATION

OBJECTIVES

Drug Pass Observation

At the completion of this session each participant will be able to:

- Identify 6 drug errors on a mock survey.
- Write 6 findings from the mock survey on the Drug Pass Observation Worksheet.
- Calculate a medication error rate.
- Document deficiencies on the Survey Report Form.

DRUG PASS OBSERVATION EXERCISE

October 24
9:00 a.m.

Resident #1603

Observed Lasix 40 mg. given orally during 9:00 A.M. pass. Physician's order had been changed on 10/22 to Lasix 20 mg. P.O.

Resident #1614

Quinidine 200 mg. P.O. T.I.D. is ordered. The A.M. dose was not poured or administered. Nurses notes did not document a reason for this omission. A review of the medical record indicated diagnosis of cardiac arrhythmia.

Resident #1622

Coumadin 4 mg. was poured during the A.M. drug pass. Not listed on unit dose Kardex. Upon questioning the nurse, it was determined that this drug was poured for the wrong resident. Nurse did not administer the drug due to surveyor intervention at time of staff handing it to resident. The surveyor did not observe this drug being administered to anyone else. (Assume drug pass observation was performed on all patients).

Resident #1615

The latest signed recap stated that this patient should receive Tagamet 400 mg Q.I.D p.c. and h.s. The MAR stated Tagamet 300 mg Q.I.D p.c. and h.s. During the 8:00 A.M. pass the surveyor observed 400 mg of Tagamet administered.

Resident #1624

Indocin 25 mg. P.O. T.I.D. is ordered. The 9:00 A.M. dose was not poured or administered to the resident. No reason was recorded for not giving the medication as ordered.

The MAR showed that this patient had received Lanoxin 0.25 mg for at least six months. The latest signed recap showed A.M. order for Lanoxin 0.125 mg Q A.M. The surveyor observed the patient receiving 0.125 mg during the 8:00 A.M. pass.

Resident #1625

Gelusil suspension 30cc P.O. Q.I.D. p.c. The 9:00 A.M. dose was administered at 9:25 A.M. while empty food trays were being collected. The nurse did not shake the suspension before it was administered.

Aspirin 5 gr., Q.I.D. P.R.N. for pain was ordered for this patient. The patient complained of pain in the morning and a 5 gr. aspirin tablet was crushed and administered in applesauce at 8:00 A.M.

Resident #1626

Valium 5 mg, Q.I.D. was ordered for this patient. The drug was packaged in a unit dose container. The nurse compared the unit dose label to the MAR twice, removed the dose and placed it in a souffle cup. The dose was administered during the 8:00 A.M. pass.

Resident #1630

Digoxin 0.125 mg. P.O. every A.M. is ordered. Digoxin 0.25 mg. was poured and administered during the A.M. pass. No pulse check was done prior to administration as ordered by the physician.

USE THE ABOVE SIZE SAMPLE TO COMPUTE THE MEDICATION ERROR RATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO 0938-

DRUG PASS WORKSHEET

PROVIDER NUMBER

SURVEY DATE

ERROR RATE ☐

INSTRUCTIONS

1. *Perform Drug Pass Observations on 20 Residents.*
2. *Record Observation of each Opportunity.*
3. *Compare Observation Notes with Physician Orders.*
4. *Calculate and Note Error Rate*
5. *Note Defeciencies on Survey Report Form.*

DEFICIENCY FORMULA

1. *One or more Significant Errors = Deficiency*
2. $\frac{\text{Significant + Non-significant}}{\text{Doses Given + Doses Ordered But Not Given}} \times 100 \quad \geq 5\% = \text{Deficiency}$

IDENTIFIER	POUR	PASS	RECORD
RESIDENTS FULL NAME, ROOM NUMBER, TIME	DRUG PRESCRIPTION NAME, DOSE AND FORM	OBSERVATION OF ADMINISTRATION	DRUG ORDER WRITTEN AS *(IF DIFFERS FROM ADMINIS ONLY)*

3

FORM HCFA-522 (11-85)

DRUG ERROR CALCULATION
(page 10-11 SOM excerpt)

How to Calculate a Medication Error Rate—In calculating the percentage of errors, the numerrator in the ratio is the total number of errors that you observe, both significant and non-significant. The denominator is all the doses you observed being administered **plus** the doses ordered but not administered. The equation for calculating a medication error rate is as follows:

$$\text{Medication Error Rate} = \frac{\text{Number of errors observed}}{\text{Opportunities for errors}} \times 100$$

Where: Opportunities for errors equals the number of doses administered **plus** the number of doses ordered but not administered.

Comments

For example, you observed the administration of drugs to 20 patients. There were a total of 47 drugs administered (47 opportunities for errors). At the completion of the reconciliation of your Observations with the physicians' orders, you find that three medication errors were made in administration and one medication was omitted (ordered but not administered). The omitted dose is included in both the numerator and the denominator. Therefore, following the above formula, your equation would be as follows:

$$\frac{3 + 1}{47 + 1} \times 100 = 8.3\%$$

4. Detailed records should be maintained by the SNF indicating receipt and disposition of the blood furnished patients. (42 CFR 405.1028(j)(6)).

5. The professional advisory group of the SNF should investigate transfusion reaction and report its recommendations regarding improvements in transfusion procedures to the SNF staff and the medical staff of the hospital or other blood supplier. (42 CFR 405.1028(j)(9)).

Upon completing the special survey, the SA should complete the Certification and Transmittal, HCFA-1539, limiting its facts and rationale to the issue with respect to 42 CFR 405.1028 and 405.1029. The SA need complete only items 1-5, 15, and 16-19 of the HCFA-1539. (See §2460 for completion instructions.)

3160. SURVEYOR PROCEDURES FOR PHARMACEUTICAL SERVICE REQUIREMENTS IN LONG-TERM CARE FACILITIES

Surveyor procedures for pharmaceutical services in skilled nursing facilities, intermediate care facilities and intermediate care facilities for the mentally retarded are contained in Appendix N of this Manual.

Part One deals with "Indicators For Surveyor Assessment of the Performance of Drug Regimen Reviews". The surveyor must use the "Indicators" in all Medicare cerfication surveys of long-term care facilities. In the absence of approved State guidelines for this purpose, the "Indicators" must also be used in all Medicaid surveys.

Part Two of Appendix N deals with "Surveyor Methodology for Detecting Medication Errors." It requires the surveyor to rely on direct observation of drug administration to detect medication errors and directs surveyors away from paper reviews in detecting these errors. It also provides guidance for judging the relative significance or non-significance of medication errors. This methodology must be carried out as a part of all Medicare certification surveys of long-term care facilities. In the absence of approved State guidelines for this purpose, this methodology must also be used in all Medicaid surveys.

APPENDIX N

Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care Facilities

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Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care Facilities

Part One: Indicators for Surveyor Assessment of the Performance of Drug Regimen Reviews

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APPENDIX N

SURVEYOR PROCEDURES FOR PHARMACEUTICAL SERVICE REQUIREMENTS IN LONG-TERM CARE FACILITIES

PART ONE

INDICATORS FOR SURVEYOR ASSESSMENT OF THE PERFORMANCE OF DRUG REGIMEN REVIEWS

Skilled nursing facilities (SNFs) and intermediate care facilities (ICFs), must perform a review of the patient's drug regimen at least monthly (42 CFR 405.1127(a) and 42 CFR 442.336(a)). In intermediate care facilities for the mentally retarded (ICFs/MR) such reviews must be performed on a regular basis (42 CFR 442.483(c)). These reviews must be performed by a pharmacist in a SNF, and by a nurse or a pharmacist in an ICF or ICF/MR. The reviews entail the examination of a number of documents (e.g., drug administration records, nursing notes, physician orders, laboratory reports). The information collected from these documents is analyzed by the pharmacist or nurse to determine if there are any potential problems with the patient's drug therapy, and whether drug therapy is achieving the stated objectives established by the physician for that patient. If there are potential problems, or if stated objectives are apparently not being achieved, the attending physician must be notified.

The following "indicators" provide more detailed instructions to States for assessing compliance with the regulations requiring drug regimen reviews (42 CFR 405.1127(a), 442.336(a) and 442.483(c)).

When conducting surveys of SNFs in the Medicare program, these criteria must be used in order for the survey to be considered valid. However, in the Medicaid program, States have the choice of using these criteria or, in the alternative, HCFA will accept other survey criteria developed by the State if the State can establish that its criteria are, at a minimum, equal to these criteria in terms of their reliability and objectivity.

I. PROPER USE OF INDICATORS

The word "indicators" is used to describe these assessment tools because most, when taken individually, could not lead to a conclusive finding of compliance or noncompliance. However, with the compliance history of the facility, they could represent strong circumstantial evidence that the pharmacist or nurse is adequately or inadequately performing good indepth drug regimen reviews. In using these indicators, a rule of number and degree of deviation should be applied. If there is high degree of deviation from all these indicators, then good reasons for the deviation must be documented. These good reasons may often be learned from the pharmacist or nurse. For this reason, it is recommended that one of these individuals be present during the survey of the drug review requirement.

II. DOCUMENTATION OF DRUG REVIEWS

A record of drug reviews must be maintained in the facility in order to demonstrate that such reviews have been performed. This record may or may not be a part of the patient's medical record depending on the policy of the facility. In any case, each patient must be identified, and documentation of one of the following circumstances must exist:

A. If no potential problems were found by the pharmacist or nurse, this is noted on a record, signed, and dated.

B. If a potential problem was found and the pharmacist or nurse deemed it not significant, then he or she described the situation, signed, and dated a record.

C. If a potential problem was found that was considered significant, the pharmacist or nurse described the situation and stated in a record that they communicated it to an individual with authority to correct it. The entry is signed and dated.

III. INDICATORS FOR ASSESSING DRUG REVIEWS

A. Reviews Performed Versus Average Census.—An obvious indicator entails a comparison of the number of reviews performed to the average census of the facility. If the average census is 100, then the number of reviews that would have been performed per month would be about 100.

However, this simple indicator cannot be absolute, and room for error must be allowed. For example, the pharmacist or nurse may have reviewed only 50 percent of the patients in a particular month, but the other 50 percent are scheduled for review the day after the survey. However, if the number of reviews falls short of patient census over a number of months, a noncompliance finding is in order.

This particular indicator may not apply to ICFs/MR, because in these facilities reviews must be performed on a "regular" basis. In ICFs/MR, reviews are required at least quarterly, but could be as frequent as monthly if the size of client census requires; however, there is no numerical quota for the number of individual reviews.

B. Reviews Performed In The Facility.—In order to perform acceptable reviews, data sources such as the patient's drug administration record, physician orders, nursing notes, and laboratory reports must be examined. For all practical purposes these data sources are only located in the facility. Thus, to adequately perform reviews, they are best carried out in the facility.

Some pharmacists claim that they perform reviews in their pharmacies using both manual and computerized patient profiles. While this type of review represents a good form of prospective review that can identify potential drug interactions, it cannot be considered to encompass the entire review.

A reviewer cannot be required to perform reviews in the facility. The regulations do not state where the reviews must be performed. However, if none of the reviews are performed in the facility, it is appropriate to question how effective and meaningful these reviews are. If they are not effective and meaningful, the standard may not be met.

C. Average Prescription Utilization.--In 1974 the average prescription utilization per skilled nursing facility patient was approximately 6.1. As a general rule, question the adequacy of drug reviews if the facility's average prescription utilization was above 6.1 per patient. There are qualifications to this indicator:

1. The 6.1 average is a national average. Regional and State variations can be significantly different. The average in the State the surveyor serves may be more meaningful. The Medicaid Management Information System, if one is available, can be of assistance in supplying this specific information.

2. The nature of the patient population (e.g., a high number of patients with multiple chronic diseases) may be such that a higher utilization is appropriate.

3. The assumption that drug regimen reviews reduce utilization may not always be true. A drug regimen review may result in additional drug utilization.

4. The pharmacist or nurse may be performing good drug reviews and recommending that drugs be discontinued, but the physician may not agree with the recommendations.

5. Analysis by the surveyor of the trend in prescription utilization is critical. The pharmacist or nurse may be changing attitudes about drug therapy and a slow improvement may be evolving. Thus, if the average is higher than 6.1 but the trend is toward reduction, the pharmacist or nurse may be adequately performing drug reviews.

6. In an ICF/MR the drug utilization is usually significantly lower. (Approximately 1 to 3 per patient per month.) ICFs' drug utilization is usually comparable to SNFs.

In order to estimate the average prescription utilization, examine a sufficient sample of charts to establish a pattern. It is not necessary to calculate an exact average. In determining the average, all legend and over-the-counter (OTC) drugs must be included.

Count any drug orders, including as needed (PRN) orders, as one prescription if one dose has been administered in the last 30 days. If a drug has been ordered but never administered in the last 30 days, do not count it in the average. Combination drugs (e.g., aspirin and codeine) should be counted as one prescription.

D. Apparent Irregularities (Potential Drug Therapy Problems).--The following may constitute drug irregularities or potential drug therapy problems. The pharmacist or nurse should question these apparent irregularities every time they are encountered. The surveyor may choose five or ten of these irregularities for each survey. If any of these irregularities are discovered (see II. Documentation of Drug Reviews), determine whether the pharmacist or nurse has brought the problem to the attention of an individual with authority to correct it. If the pharmacist or nurse has done this, then little evidence of deviation from this indicator is present. Do not go further than determining that the pharmacist or nurse has brought an apparent irregularity to the attention of a responsible party. It is not necessary to ascertain the disposition of the recommendation made by the pharmacist or nurse. This could be construed as Federal interference with the practice of medicine, which is prohibited by Section 1801 of the Social Security Act.

Keep the following considerations in mind when applying the apparent irregularity indicator:

1. The indicators are not standards of practice. They are potential drug therapy problems that require closer review. Documentation that closer review is being performed indicates compliance with the drug review requirements.

2. Where the pharmacist or nurse has stated that an apparent irregularity has been communicated to an individual with authority to correct it and the recommendation has been noted, document this only once. Thereafter, monthly reports can state "See previous note dated _______."

3. Various tests that are recommended to monitor drug therapy may be performed in another facility, but the results of these tests may not be in the patient's record at the SNF, ICF or ICF/MR. If the pharmacist or nurse has knowledge of such tests, document this in the record of drug reviews. If such documentation does not exist, assume that the tests have not been performed.

Verify that in the record of drug reviews the pharmacist or nurse has commented on the following drug therapy circumstances whenever they occur. (See II. Documentation of Drug Reviews.)

1. Multiple orders of the same drug for the same patient (e.g., by different routes of administration or the same chemical entity ordered by different brand names).

2. Drugs administered in disregard of established stop order policies.

3. As needed (PRN) drug orders administered as directed every day for more than 30 days.

4. Patients receiving more than one multi-vitamin per day.

5. Patients taking three or more laxatives concurrently. Commonly used laxatives are as follows:

Classification	Brand Names
Bulk:	Metamucil
	Effersyllium
	Konsyl
	Modane Bulk
Fecal Softeners:	Colace
	Dialose
	Dorbantyl
	Modane Soft
	Surfak
	Peri-Colace
Lubricant:	Agoral
	Haley's M.O.
	Mineral Oil
Stimulant:	Dulcolax
	Senokot
	Cascara Sagrada
	Neoloid
Saline:	Milk of Magnesia (MOM)
	Fleets Enema

6. Use of major tranquilizers (see number 10 for list) or antidepressants (see number 14 for list) for less than three days.

7. Continuous use of the following hypnotic drugs for more than 30 days.

Generic Name	Brand Names	Usual Dose
secobarbital	Seconal	100-200 mg.
pentobarbital	Nembutal	100-200 mg.
butabarbital	Butisol	50-200 mg.
amobarbital	Amytal	100-300 mg.
methyprylon	Noludar	200-400 mg.
glutethimide	Doriden	250-1000 mg.
methaqualone	Parest,	150-400 mg.
--	Quaalaude	
chloral hydrate	Noctec	500-1500 mg.
ethchlorovynol	Placidyl	500-1000 mg.
flurazepam	Dalmane	15-30 mg.

8. Concomitant use of two or more hypnotic drugs listed in number 7.

9. Hypnotic drugs listed in number 7 administered in excess of the listed dosages.

10. Concomitant use of any two or more of the following antipsychotic drugs.

Generic Names	Brand Names	Usual Daily Anti-Psychotic Dosage
chlorpromazine	Thorazine, others	400-1600 mg.
triflupromazine	Vesprin	100-200 mg.
thioridazine	Mellaril	400-800 mg.
mesoridazine	Serentil	100-500 mg.
piperacetazine	Quide	40-160 mg.
acetophenazine	Tindal	60-300 mg.
butaperazine	Repoise	20-160 mg.
carphenazine	Proketazine	75-400 mg.
fluphenazine	Prolixin, Permitil	5-40 mg.
(a) fluphenazine decanoate		12 1/2-100 mg.
(b) fluphenazine enanthate		12 1/2-100 mg.
perphenazine	Trilafon	8-64 mg.
trifluoperazine	Stelazine	10-80 mg.
chlorprothixene	Taractan	400-1600 mg.
thiothixene	Navane	10-60 mg.
haloperidol	Haldol	5-100 mg.
molindone	Moban, Lidone	20-225 mg.
loxapine	Loxitane, Daxolin	50-250 mg.

11. Use of the antipsychotic drugs listed in number 10 in excess of the listed dosage ranges.

12. Use for patients over 65 of the antipsychotic drugs listed in number 10 in excess of one-half the listed dosage ranges.

13. Use of the following drugs when their dosages exceed the following ranges:

Generic Names	Brand Names	Usual Daily Dosage Age Under 65	Usual Daily Dosage Age Over 65 and Under 12
chlordiazepoxide	Librium	20-100 mg./day	10-40 mg./day
diazepam	Valium	10-60 mg./day	2.5-20 mg./day
oxazepam	Serax	15-90 mg./day	10-60 mg./day
chlorazepate	Tranxene	15-60 mg./day	7.5-30 mg./day
prazepam	Verstran	20-60 mg./day	10-30 mg./day
lorazepam	Activan	2-6 mg./day	0.5-3 mg./day
meprobamate	Equanil, Miltown	400-1600 mg./day	200-600 mg./day

14. More than two changes of an antidepressant within a 7-day period. Commonly used antidepressants are as follows:

Generic Names	Brand Names	Usual Daily Dosage
amitriptyline	Elavil	100-300 mg./day
desipramine	Norpramin, Pertofrane	100-300 mg./day
doxepin	Sinequan, Adapin	100-300 mg./day
imipramine	Tofranil, SK pramine	100-300 mg./day
nortriptyline	Aventyl, Pamelor	50-150 mg./day
protriptyline	Vivactil	20-60 mg./day

15. Use for patients over 65 of antidepressants listed in number 14 in excess of one-half the listed dosage ranges.

16. Use of the antidepressants listed in number 14 in excess of the listed dosage ranges.

17. Patients who repeatedly lose seizure control while taking anticonvulsants (e.g., phenytoin - Dilantin, phenobarbital, or primidone - Mysoline).

18. Patients who are taking thyroid drugs and have not had some assessment of thyroid function (e.g., Free T4 Level, T3 Resin update, Free Thyroxin update). Commonly used thyroid drugs are as follows:

Generic Names	Brand Names
levothyroxine	Synthroid
liothyronine	Cytomel
Thyroid Extract	Various Brands

19. Patients who are taking antihypertensives and have not had a blood pressure recorded at least weekly. Commonly used antihypertensives are as follows:

Generic Names	Brand Names
reserpine	Serpasil, and generic brands
hydrochlorothiazide	Hydrodiuril
chlorothiazide	Diuril
methyldopa	Aldomet
propranolol	Inderal
guanethidine	Ismelin
chlorthalidone	Hygroton
clonidine	Cetapres
hydralazine	Apresoline
prazosin	Minipress
furosemide	Lasix

20. Patients who are on anticoagulant therapy and have not had some assessment of blood clotting function at least every month. The most common blood clotting function test is prothrombin time. Commonly used anticoagulants are as follows:

Generic Names	Brand Names
warfarin	Coumadin
bishydroxycoumarin	Dicumarol

21. Patients who are on cardiotonic therapy (e.g., digoxin, Lanoxin, digitoxin, digitalis) and have not had a daily apical pulse rate recorded in the chart OR exhibit an apical pulse consistently below 60 or above 100.

22. Patients who are taking insulin or oral hypoglycemics and have not had a urine sugar test at least daily OR a fasting blood sugar or a 2-hour post-prandial at least every 60 days. Commonly used hypoglycemics are as follows:

Generic Names	Brand Names
tolbutamide	Orinase
chlorpropamide	Diabinese
acetohexamide	Dymelor
tolazamide	Tolinase

23. Patients who are taking beta blockers and have no daily pulse rate recorded on the chart OR have an apical pulse rate consistently below 50. Commonly used beta blockers are as follows:

Generic Names	Brand Names
propranol	Inderal
metoprolol	Lopressor

24. Patients who are taking iron preparations, folic acid or Vitamin B 12, and have not had a red blood cell assessment (e.g., hemoglobin, hematocrit) during the first month of therapy. Commonly used iron preparations are as follows:

Generic Names	Brand Names
ferrous sulfate	Feosol
iron dextran complex	Imferon
ferrous gluconate	Fergon

25. Patients who are taking antiarrhythmic drugs and have not had apical pulse rate recorded daily. Commonly used antiarrhythmic drugs are as follows:

Generic Names	Brand Names
propranolol	Indernal
digoxin	Lanoxin

26. Use of methenamine mandelate or hippurate (Mandelamine or Hiprex) if the urinary bacterial count has not been determined, at least once, 30 days after therapy was initiated.

27. Patients taking methenamine mandelate or hippurate who have not had a urine pH determination within 30 days after therapy was initiated.

28. Use of nitrofurantoin (Furadantin, Macrodantin) if any one of the following circumstances exists:

a. The drug is used for conditions other than treatment or prophylaxis of urinary tract infections.

b. Blood urea nitrogen or serum creatinine levels are not recorded on the chart.

c. The urinary bacterial count has not been determined at least once 30 days after therapy was initiated.

29. Three or more orders for analgesics used in combination. Commonly used analgesics are as follows:

Generic Names	Brand Names
aspirin	Empirin
acetaminophen	Tylenol
codeine	--
aspirin with codeine	Empirin with Codeine
meperidine	Demerol
oxycodone, aspirin,	Percodan
phenacetin, caffeine	Darvon Compound
propoxyphene, aspirin	

30. Patients taking diuretics who have not had a serum electrolyte (Na,K,Cl,HCO_3) determination within 30 days after initiation of therapy. Commonly used diuretics are as follows:

Generic Names	Brand Names
hydrochlorothiazide	Hydrodiuril, Esidrix
chlorothiazide	Diuril
chlorothalidone	Hygroton
furosemide	Lasix
acetazolamide	Diamox
ethacrynic acid	Edecrin

31. Patients taking diuretics (see number 30 for list) and cardiotonics (see number 21 for list) who have not had a serum electrolyte determination within 30 days after initiation of the cardiotonic therapy and every 6 months thereafter.

32. Patients who are taking the following antiarthritic drugs continuously for 30 days, and have not had at least one CBC determination after initiation of therapy.

Generic Names	Brand Names
phenylbutazone	Butazolidin, Azolid
oxyphenbutazone	Tandearil

E. Irregularities Identified by the Pharmacist or Nurse.--It is reasonable to expect that at least five irregularities excluding those dealing with drug administration problems (e.g., charting error, transcription error), per 100 patient months should have been recorded by the pharmacist or nurse. Documentation of less than five irregularities per hundred patient months may be another indication of poor drug reviews.

PART TWO

SURVEYOR METHODOLOGY FOR DETECTING MEDICATION ERRORS

Regulations for SNFs and ICFs and ICFs/MR endeavor to minimize medication errors. For SNFs, 42 CFR 405.1124(h) states that "Drugs are administered in accordance with written orders of the attending physician." This requirement precludes drugs from being administered in any way that deviates from physicians' written orders. For ICFs, 42 CFR 442.334(a) requires that medications administered to a resident be ordered either in writing or orally by "the resident's attending or staff physician." The interpretive guideline for this regulation requires that drugs and biologicals are administered as ordered by the physician; emphasis is placed on administering drugs at the prescribed time. This requirement prohibits drugs from being administered in any way other than as ordered by the physician. For ICFs/MR, medication errors are addressed by the procedural requirements of 42 CFR 442.483(d) ("safe administration and handling of drugs") and 42 CFR 442.484(a), (c) and (d) requiring that (1) only appropriately trained staff administer drugs; (2) the ICF/MR have a stop order on all drugs; and (3) medication errors be recorded and reported.

I. MEDICATION ERROR DETECTION METHODOLOGY

Use an observation technique to determine medication errors. This means that you must observe the administration of drugs, (preferably on several different drug "passes"); record what is observed; and reconcile the record of observation with the physician's drug orders to determine whether or not medication errors have occurred.

Do not rely solely on a paper review to determine medication errors. Detection of blank spaces on a medication administration record does not constitute the detection of actual medication errors. Paper review only identifies possible errors. Experience has shown that facility staff are likely to correct the paper rather than correct the errors.

A. Observation Technique.--You must know without doubt, what drugs, in what strength and dosage forms, etc. are being administered. This is accomplished prior to drug administration and may be done in a number of ways depending on the surveyor and depending on the drug distribution system used (e.g., unit dose, vial system, punch card).

1. Identify the drug product. There are two principal ways to do this. In most cases, they are used in combination.

a. Identify the product by its size, shape and color. Many drug products are identifiable by their distinctive size, shape, or color. This technique is problematic because not all drugs have distinctive sizes, shapes, or colors.

b. Identify the product by observing the label. When the punch card or the unit dose system is used, you can usually observe the label and adequately identify the drug product. When the vial system is used, observing the label is sometimes more difficult.

Another method of drug identification is to attach pre-numbered stickers. This is a variation to the observation technique and is described under B.

2. Observe and record the administration of drugs ("pass"). Follow the person administering drugs and observe patients receiving drugs (e.g., actually swallowing oral dosage forms). Be neutral and as unobtrusive as possible during this process.

Make every effort to observe 20 patients from several different drug "passes" so you will have an assessment of the entire facility rather than one staff member on one drug pass.

Note every detail on your record of the drug administration. For example, "eye drops administered in both eyes" or "nurse took pulse," or "patient swallowed nitroglycerin" or "all drugs crushed and administered in apple sauce." Identifying patients can present a problem. Some long-term care facilities do not use arm identification bands, or assume correctness of the patient by relying on the actions of the nurse and the response of the patient.

3. Reconcile your record of observation with physician's orders. Compare the record of observation with the most current signed orders for drugs. This comparison involves two distinct activities:

a. For each drug on your list: Was it administered according to the physician's orders? For example, in the correct strength and by the correct route? Was there a valid order for the drug? Was the drug the correct one?

b. For drugs not on your list: Are there orders for drugs that should have been administered but were not? Examine the record for drug orders that were not administered and should have been. You are now looking for omitted doses -- one of the most frequent types of errors.

You should now have a complete record of what you observed and what should have occurred according to the physicians' orders. Determine the number of errors by adding the errors on each patient. Before concluding for certain that an error has occurred, discuss the apparent error with the nurse who administered the drugs. There may be a logical explanation for an apparent error. For example, a surveyor once observed that a patient had received Lasix 20 mg, but the order was for 40 mg. This was an apparent error in dosage. But the nurse showed the surveyor another more recent order which discontinued the 40 mg order and replaced it with a 20 mg order.

B. Variation to the Observation Technique - Use of Numbered Stickers for Product Identification.—When the vial system of drug distribution is used, the visual identification of the drug product may not always be possible. You may need to use numbered stickers attached to the vial caps to identify the drug product.

1. Label drug vials with numbered stickers. Prior to the drug "pass" choose a nursing station at random. Before the preparation for administration ("pour") begins, place numbered stickers on each medication vial. (Note: The stickers are 3/4 inch in diameter, can be obtained from most office supply stores and are manufactured by both Avery and Dennison. Number the stickers in advance with consecutive numbers from 1 to about 300. Be sure to write the numbers as large as possible.) It is not necessary to place stickers on large bottles of drugs such as Gelusil or Maalox as the labels on these containers are large enough to be seen from a distance. Make sure that the "pass" to be observed includes at least 20 patients receiving drugs. (When the numbered sticker variation is used, it is, of course, impossible to observe different staff on different drug "passes", unless you watch different passes from the same nursing station.)

2. Observe the preparation for "pour" and record the numbers of the drugs "poured" on the left hand column of a plain sheet of paper. If more than one unit of a drug is placed into a patient's souffle cup, write the number of units next to the drug number. For example, if 2 units of drug "214" are "poured" write "214-2." If one unit, write "214." If 3 units, "214-3." During the "pour," make sure that each unit prepared for a particular patient goes into that patient's souffle cup. Also note the patient's name and room number. At this point, your record should look like the following example:

John Smith	214-2
Room 137B	215
	217
	220
	216

After this step proceed with "Observe and Record the Administration of Drugs" as described under A.2.

3. Decode drug sticker numbers. After the "pass," return to the drug room and record the drug name and strength which corresponds to each sticker number. Do this for only those 20 patients you have included in your study. Write the drug name and the strength next to patient's name and room number. At this point, your record should look like this example:

John Smith	214-2 - Aspirin 5 gr
Room 137B	215 - Valium 5 mg
	217 - Digoxin 0.25 mg Pulse Taken
	220 - Tetracycline 250 mg
	216 - Colace

After decoding proceed with "Reconcile your record of observation with physician's orders" as described under A.3.

C. Dose Reconciliation Technique: Supplement to the Observation Technique.—When an omission error has been detected through the observation technique the dose reconciliation technique can sometimes enable you to learn how frequently an error has occurred in the past. Learning about the frequency of an error can assist you in judging the significance of the error. (See VI. Significant and Non-Significant Medication Errors.) The dose reconciliation technique requires a comparison of the number of doses remaining in a supply of drugs with the number of days the drug has been in use and the directions for use. For example, if a drug were in use for 5 days with direction to administer the drug 4 times a day, then 20 doses should have been used. If a count of the supply of that drug shows that only 18 doses were used (i.e., two extra doses exist) and no explanation for the decrepancy exists (e.g., patient refused the dose, or patient was hospitalized) then two omission errors may have occurred.

The dose reconciliation technique can only be used in facilities that indicate the number of drugs received, and the date and the specific "pass" when that particular supply of drugs was started. Unless this information is available do not use this technique. If this information is not available there is no Federal authority under which you may require it, except for controlled drugs.

II. REDUCING TIME REQUIRED FOR SURVEYING OTHER DRUG STANDARDS.

A. Requirements Covered by the Medication Error Detection Methodology.—The intention of certain procedural requirements located at 42 CFR 405.1124(g) is to avoid medication errors. However, compliance with these requirements is automatically verified via the medication error detection methodology. Thus, using the observation technique replaces the expenditure of surveyor time to determine compliance with the following requirements of 405.1124(g):

1. Drugs to be administered are checked against physician orders. (SNF tag F183).
2. The patient is identified prior to administration of a drug. (SNF tag F184).
3. Drugs and biologicals are administered as soon as possible after doses are prepared. (SNF tag F187).
4. Drugs are administered by the same person who prepared the doses for administration. (SNF tag F188).

In addition to the above procedural requirements, the following labeling and record requirements are covered by the medication error detection methodology.

1. The standard on labeling drugs and biologicals. (42 CFR 405.1127(c); SNF tag F278).

2. Each patient has an individual medication record. (42 CFR 405.1124(g); SNF tag F185).

B. Requirements of Less Priority.--The following requirements pursue regulatory objectives that are less important than the identification and prevention of medication errors. As such they should receive relatively less surveyor attention.

1. Review of records of the receipt and disposition of controlled drugs (see 42 CFR 405.1127(b) or SNF Survey Report tag F276; no similar requirement for ICFs).

2. Determinations of whether all drugs are locked. (See 42 CFR 405.1124(i) or SNF Survey Report tag F204; no similar requirement for ICFs).

3. Review of the pharmaceutical services committee. (See 42 CFR 405.1127(d) or SNF Survey Report tag F279, F280, F281 and F283; no similar requirement for ICFs).

III. RULES FOR DETERMINING MEDICATION ERRORS

A. Timing Errors.--Count a wrong time error if the drug is administered 60 minutes earlier or later than its scheduled time of administration. To determine the scheduled time, examine the facility's policy relative to dosing schedules. The facility's policy should dictate when it administers a.m. doses, or when it administers the first dose in a 4 times a day dosing schedule. In deciding on wrong time errors, be sensitive to the possibility of your observations slowing the drug "pass," and adjust the number of wrong times errors accordingly. Do not count wrong-time errors for drugs administered on a once-a-day basis (e.g., digoxin). Always count wrong-time errors for drugs not correctly administered in relation to meals (after meals, before meals).

B. Physician's Orders.--The latest recapitulation of the drug orders (monthly "recap") is sufficient for determining whether a valid order exists provided the physician has signed the "recap." The signed "recap" and subsequent orders constitute a legal authorization to administer the drug. Attempts to find original orders in the physician's handwriting are usually too time consuming.

C. Reporting Errors.--Describe to the facility each error that you detect (e.g., Mary Jones received digoxin 0.125 instead of 0.25 mg). You are not required to analyze the errors and come to any conclusions on how the facility can correct them. If you wish to offer this consultation you are encouraged to do so. But the advice you give must not be offered as if the facility had to follow it. Do not attempt to categorize errors into various classifications (e.g., wrong dose, wrong patient). The important thing to stress is that an error occurred and that future errors must be avoided.

D. Observe Morning "Pass".--It is preferable to watch the morning drug administration pass because that is when most doses are administered in long-term care facilities and hence offers the greatest opportunity to observe errors.

E. Observe Several Individuals.--Strive to observe several individuals administering drugs in the facility so that an assessment of medication errors will be more broadly based. This requires the observation of several "passes" at the same time or different times of the day. If you use numbered stickers to identify the drugs, the "passes" that are observed will need to come from the same drug storage area but may be administered by different individuals. In a large ICF/MR, you may need to go to several buildings in order to observe several individuals administering drugs.

IV. WHEN TO WRITE A DEFICIENCY FOR MEDICATION ERRORS

Regulation 405.1124(h) (SNF tag F190), regulation 442.334(a) (ICF tag number T123) or regulation 442.484(d) (ICF tag W496) must be marked out of compliance if you determine that medication errors are jeopardizing the health and safety of patients. Use the following criteria in deciding when to write a deficiency for medication errors:

A. If one or more significant medication error occurs (see following discussion on significant and insignificant errors), or

B. If insignificant and significant medication errors together amount to five percent or more of the total opportunities for errors.

The basis for writing a deficiency after a particular tolerance has been exceeded relates to the probability that these errors are symptomatic of a drug distribution system that is faulty and that will eventually produce significant errors that can jeopardize the health and safety of patients. The five percent minimum tolerance level was chosen on the basis of the best available information relative to what is achievable in terms of contemporary drug distribution systems, and the level of sophistication in methodologies for detecting medication errors. Only experience with these variables will permit a determination whether the five percent is appropriate or whether it should be revised.

V. HOW TO CALCULATE A MEDICATION ERROR RATE

In calculating the percentage of errors, the numerator in the ratio is the total number of errors that you observe, both significant and insignificant. The denominator is all the doses you observed being administered plus the doses ordered but not administered. The equation for calculating a medication error rate is as follows:

Medication Error Rate = Number of Errors Observed divided by the Opportunities for Errors x 100.

Where: Opportunities for Errors equals the number of doses administered plus number of doses ordered but not administered.

VI. SIGNIFICANT AND NON-SIGNIFICANT MEDICATION ERRORS

A. General Rules for Determining Significance.--The relative significance of medication errors is a matter of professional judgement. Surveyors who are responsible for assessing these requirements must be qualified to exercise such judgement (e.g., pharmacists, nurses). Follow three general rules in determining whether a medication error is significant or not:

1. Patient Condition.--The patient's condition is an important factor to take into consideration. For example, a potent diuretic erroneously administered to a dehydrated patient may have serious consequences but if administered to a patient with a normal fluid balance may not. If the patient's condition requires rigid control, a single missed or wrong dose can be highly significant.

2. Drug Category.--If the drug is from a category that usually requires the patient to be titrated to a specific blood level, a single medication error could alter that level and precipitate a re-occurrence of symptoms or toxicity. This is especially true if the half life of the drug is short. Examples of drug categories which require titration of patient blood levels include anticonvulsants, anticoagulants, and antiarrhythmic, antianginal and antiglaucoma agents.

3. Frequency of Error.--If an error is occurring with any frequency, there is more reason to classify the error as significant. For example, if a patient's drug was omitted several times, as verified by reconciling the number of tablets delivered with the number administered, classifying that error as significant would be more in order. This conclusion may be especially valid when taken in concert with the patient's condition and the drug category.

B. Examples of Significant and Non-Significant Medication Errors.--Examples of medication errors that have actually occurred in long-term care facilities are presented below. Some of these errors are identified as significant. This designation is based on expert opinion without regard to the status of the patient. Most experts concluded that the significance of these errors, in and of themselves, have a high potential for creating problems for the typical long-term care facility patient. Those errors identified as non-significant have also been designated primarily on the basis of the nature of the drug. Patient status and frequency of error could classify these errors as significant.

1. OMISSIONS (DRUGS ORDERED BUT NOT ADMINISTERED AT LEAST ONCE)

HALDOL 1mg BID	NS
MOTRIN 400 mg TID	NS
QUINIDINE 200mg TID	S
TEARISOL Drops 2 both eyes TID	NS
INDOCIN 25mg TID pc	NS
LIORESAL 10 mg TID	NS

THORAZINE 25 mg BID	NS
AMPICILLIN 500 mg TID	NS
METAMUCIL one packet BID	NS
INDERAL 20mg one every 6 hours	S
MULTIVITAMIN one daily	NS
MYLANTA SUSP. one oz. TID AC	NS
NITROL OINT. one inch	S
LIBRIUM 10mg one TID	NS
CORTISPORIN OTIC drop 4 to 5 left ear QID	NS
ALDACTONE 25 mg QID	NS

2. UNAUTHORIZED DRUG (DRUGS ADMINISTERED WITHOUT A PHYSICIAN'S ORDER)

FEOSOL	NS
COUMADIN 4 mg	S
LASIX 40 mg	S
ZYLOPRIM 100 mg	NS
TYLENOL 5 gr	NS
TRIAVIL 4-25	NS
MULTIVITAMINS	NS
MOTRIN 400 mg	NS

3. WRONG DOSE

ORDERED	ADMINISTERED	
ISOPTOCARPINE 1% one drop in the left eye TID	Three drops in each eye	NS
EPINAL 1% one drop in eyes BID	Three drops in each eye	NS
DIGOXIN 0.125 mg everyday	0.25 mg	S
LASIX 20 mg one daily	40 mg	NS
AMPHOJEL 30 cc QID	15cc	NS
SLOW K two TID	one	NS
DILANTIN 125 SUSP 12cc	2cc	S
LASIX 40 mg daily	20 mg	NS

4. WRONG ROUTE OF ADMINISTRATION

ORDERED	ADMINISTERED	
HYDERGINE 0.5 mg S.L. BID	Patient swallowed	NS
CORTISPORIN OTIC DROPS 4 to 5 left ear QID	Left Eye	S

5. WRONG DOSAGE FORM

ORDERED	ADMINISTERED	
COLACE LIQUID 100 mg BID	capsule	NS
MELLARIL 10 mg Tab TID	concentrate	NS (If correct dose was given)
DILANTIN KAPSEALS 100 mg three Kapseals p.o. HS	Prompt Phenytoin 100 mg three capsules p.o. HS	S (Parke Davis Kapseals have an extended rate of absorption. Prompt phenytoin capsules do not.)

6. WRONG DRUG

ORDERED	ADMINISTERED	
TYLENOL 325 mg	ASCRIPTIN (Routinely)	S

7. WRONG TIME

ORDERED	ADMINISTERED	
INDOCIN 25 mg PC	AC	NS
PERIACTIN 4 mg PC	AC	NS
DIGOXIN 0.25 Daily AT 8 AM	At 9:15 am	NS
TETRACYCLINE 250 mg QID AC AND HS	PC	S

S - Significant
NS - Not Significant

OIRR

OBJECTIVES

Resident Observation/Interview/Record Review

At the completion of this session, each participant will be able to:

- Identify specific indicators of potential problems in nursing, dietary, social services and medical services from two case studies.
- List specific indicators of potential problems on the Observation/Interview/Record Review Worksheet.
- Document deficiencies on the Survey Report Form.

IN-DEPTH RESIDENT OBSERVATION/ INTERVIEW/MEDICAL RECORD REVEIW EXERCISE

October 24

Resident B — #1602

Rationale for selection into sample (from Residents Selected for In-depth Review Worksheet). Two decubiti on left foot -- NG feeding -- catheter -- urine odor in room.

Mrs. B is an 83 year old female who was admitted to the nursing home 18 months ago.

Observation and Interview Excerpts

When you enter Mrs. B's room at 10:30 a.m. on 10/24, you find her lying in bed on her right side. The head of her bed is elevated about 45 degrees, and she has slipped down in the bed. Her eyes are closed. She opens them as you say her name and then closes them again. Her lips are dry and chapped. Her hair appears oily and is uncombed. As you ask her questions she responds unintelligibly, occasionally moaning.

Nursing staff enter her room to do a.m. cares without knocking. They do not pull the curtain between the beds. You ask to stay to observe her physical condition.

Her sacral decubitus measures approximately 2 1/2 cm. in diameter and is approximately 3 1/2 cm. deep and has foul, purulent drainage. The decubitus on her left ankle and dorsum also exhibits purulent drainage. Size is 1" x 1" and 1.5" x 1", Stage III and Stage IV. Her elbows and skin between her knees is reddened. You notice a reddened area and a pea-sized break in skin on her left hip.

As the nursing staff changes her dressing, you note that they do not wash their hands prior to or after changing the dressings. They also lay the old dressing on the overbed table next to the sterile dressing and then dispose in wastebasket in bathroom. The supplies used in the dressing change are also placed on the overbed table and then taken back to treatment room.

There is a strong urine smell in the room. The radio on her dresser is tuned into a popular music station. There is little evidence of personal belongings on dresser or bedside stand. She is dressed in a hospital gown. No footboard is present. No pillows are used to position her.

Medical Record Reivew

Admitting Diagnoses

Rheumatoid arthritis
ASHD with CHF
Chronic brain syndrome
Hypertension
Chronic GU infections
Peripheral vascular disease
S/P left hip fracture
Level of Care: Skilled

Social History

Mrs. B has been widowed for 12 years. She has two daughters and several grandchildren who live in the area. Two sons live in faraway states.

Prior to her admission, she was hospitalized with a hip fracture. She was discharged to her daughter's home, but within a month admitted to the nursing home because the daughter was unable to provide all the necessary care.

Activities

Activity progress notes written two months ago indicated "she is too unresponsive to participate in activities. Continues to be observed for any signs of awareness during weekly contacts. Radio is taken to her room and soft music played. She does not appear to be aware of it".

Dietary

No weight, nor height is recorded. NG tube feedings of 200 cc Ensure every six hours followed by 50 cc water were started six months ago because she was not eating. Progress notes for past two months indicated she "has no new problems" and "problems remain the same".

Medical

Physician's orders include:

Apresoline 10 mg. every four hours if systolic B/P over 200
Mom 30 cc with Cascara 10 cc via ngt prn
Tobromycin 80 mg. IM every 12 hours for five days (ordered two days ago)
Bactrim, one tablet crushed and give via ntg BID for three weeks (ordered two days ago)
Fleets enema prn
Foley cath to straight drainage
Irrigate Foley with N/S 20 cc prn
Vital signs weekly
Weight monthly
SS enema prn
Clean decubitus ulcers with Saline solution
Pack with Debrisan. Cover with 4 x 4 BID
B/P qd
Siderails for personal safety prn
May participate in all social activities as tolerated
N/G tube with 200 cc Ensure every six hours followed by 50 cc water

Physician's progress note written 50 days ago indicated all systems are negative for findings, poor prognosis, and maintenance nursing care required.

Nursing

The most recent nursing summary written three weeks ago indicated: "Mrs. B is bedridden and unresponsive to all stimuli except pain. She tolerates the NG tube feedings well. Has a Foley catheter which drains well; urine cloudy. Decubitus care to open areas on sacrum and left ankle and dorsum of foot. No new problems noted."

Upon reviewing nursing progress notes you gather the following information:

1. Decubitus on sacrum approximately 2 1/2 cm. on surface and 3 1/2 cm. under the skin. Small amount bloody drainage. Showing no decrease in size.

2. Decubitus left ankle and dorsum 1" x 1" and 1.5" x 1", Stage III and Stage IV. Slight amount of yellowish drainage. No assessment of reddened skin on elbows and between knees. No assessment of open area on left hip. No wound cultures performed.

3. Contractures of all extremities.

4. Towel roll in hands.

5. NG tube becomes plugged occasionally and is replaced. At one point two weeks ago she was vomiting old tube feeding.

6. Occasional loose stools.

7. Two days ago physician was notified of temp of 101.2 (R), P-120, R-18, B/P 230/100. Urinalysis was ordered as well as antibiotics. Results of urinalysis from phone report indicate increased WBC, blood, and bacteria present. Culture and sensitivity in progress.

Multidisciplinary Plan (Dated as reviewed and revised three weeks ago.)

Long Term Goal: Provide safe comfortable environment which promotes independent living to the extent possible due to multiple disease process.

Problem/Need	Approach	Goal
Needs R.O.	All staff provide 24 hour R.O.	Become oriented to facility
	SS -- visit once a week for 10 minutes.	To communicate with resident in whatever ways possible
	AT -- RO when make weekly visit.	
	Tune radio to soft music -- not "pop" music.	
No Social Service referrals at this time	SS will monitor her needs. Meet with family upon request.	Maintain present social service status
Total assist with ADL	Daily bed bath. Oral care BID. Total dressing and grooming by staff. Ensure 200 cc every 4 hours prn Ngt Turn every two hours.	Will be clean, comfortable, and well groomed

Incontinent of feces and urine	Foley cath in place to straight drainage. Irrigate with 200 cc N/S prn. Cath care BID. Record Foley output every eight hours. Clean and dry every two hours as necessary. MOM prn if no BM. Record BMs every eight hours.	Clean, dry, free of body odor or skin breakdown
ASHD with CHF	Observe for excessive edema, SOB.	Free of complication of heart disease
Hypertension	BP daily and record. Appresolene per ntg if systalic B/P over 200. Notify MD of any marked changes.	Control BP within normal limits
Prevent GU Infection (has Foley Catheter)	Ensure 200 cc followed by 50 cc water every six hours. Irrigate Foley PRN with 20 cc. N/S if cloudy or thick mucous shreds noted. Foley cath to straight drainage. Change Foley every month. Cath care BID.	Free of infection; prevent recurrence

(Added to plan three weeks ago)

Decubitus (Sacrum and left ankle and dorsum of foot)	Treatment as ordered.	Clean skin with no broken area

IN-DEPTH RESIDENT OBSERVATION/ INTERVIEW/MEDICAL RECORD REVIEW EXERCISE

October 24
Resident R — #1611

Rationale for selection into sample (as per Residents Selected for In-depth Review Worksheet). Staff entered resident room without knocking or announcing themselves and left without closing the door. Ambulatory -- Slight urine smell in room -- Few personal belongings.

Mrs. R is a 77 year old female who was admitted to the nursing home four months ago.

Observation and Interview Excerpts

Q = Question asked by surveyor
A = Response by resident

Introductory remarks by surveyor.

Q. What help do you need to take a bath?
A. I need someone to help me get in the tub. I can wash everything except my back and feet. I can't wash my hair anymore either.

Q. Can you get in and out of bed by yourself?
A. I manage; it's a little high. (You notice bed is somewhat elevated.)

Q. Do you have any trouble holding your urine?
A. Sometimes, like when I cough. I usually have to use the bathroom right away when I feel like I have to go. Sometimes my roommate is using it, and I lose some of my urine waiting on her. Now I just put one of these washcloths in my underpants.

Q. Do you have any trouble with your bowels?
A. Once in a while I'm plugged up but they give me something for it.

Q. Do you need any help eating?
A. No. Sometimes I have trouble seeing what's on the plate. Some of those cartons give me trouble, too. My left hand isn't as strong since my stroke. I manage though.

Q. Does the staff help you open the cartons?
A. They're too busy with the others who can't feed themselves.

Q. How's your appetite?
A. OK. I guess. I'm not usually very hungry.

Q. How does the food taste?
A. It's OK -- It's hard to eat food someone else makes. My husband always said I was the best cook for miles around. I made up many of my own recipes. It's not like my food. They give me too much to eat. I keep telling them to give it to the men -- they need it more than I do.

Q. You receive a special diet.
A. Yes, I'm a diabetic, have been for years.

Q. What help do you need when getting dressed?
A. I try to do it myself. I suppose I don't look very good today. I wasn't expecting any visitors. I can't see as well as I used to, and my fingers don't work as well anymore. I used to sew my own clothes. I kept up with the styles. I can't do that anymore. I'm just old and useless. I don't know why I have to keep on living. I've lived a good life and now there's not much left for me.

Q. Who is here that you can talk with about how you're feeling?
A. Some of the girls stop in, but they don't have much time. There are so many other people here who need help. I try not to take much of their time.

Q. These sores on your arms. How did you get them?
A. I've had these for a long time, before I came here. I guess I bumped myself. They don't seem to want to heal. I guess I pick at them. I don't mean to, I just find myself doing it.

Q. What do the staff do for these sores?
A. Nothing, they just tell me to quit picking!

Q. You say you can't see well.
A. No, my eyesight is getting pretty bad. I used to like to read and crochet. I don't do any of that anymore.

Q. Who helps you with this problem?
A. I get along OK. The doctor says its cataracts and I could have surgery but I'm too old to do anything like that. It doesn't make any difference now.

Q. What activities do you attend here?
A. They ask me to go to some activities, but I'm not interested in

that. That's for the younger people. When I lived at home, I kept busy. I used to belong to the women's church group, and did some volunteer work at the school. My husband and I belonged to a couples group. We did alot of things. Now he's gone and so are many of the others.

Q. What kinds of problems have you had since you've been here?
A. I really have not had any problems. As I've said the girls are pretty busy. I don't like to bother them if I don't have to. They're good people, I hear them talking to each other in the halls and other rooms about their families and plans. It's hard to be old and useless.

Q. Do you know what charges are covered by Medicare/Medicaid for your stay here?
A. My son takes care of that, I don't get involved in the money end.

Q. Does anyone here check your letters before you send them?
A. I can't see well enough to write.

Q. Is your mail sealed when you get it?
A. I don't get much mail. I've never noticed.

Q. Can you make phone calls by yourself?
A. I don't have anyone to call. My daughter-in-law is busy with the kids. My daughter calls me once a month or so, but you know the phone is at the nurses' desk and they need to use it, so I don't talk very long.

Q. When you have visitors do you have privacy?
A. I don't have many visitors. I don't know anyone in this town. All my friends who are left live in my hometown and it's too far for them to come.

Q. Is there a Resident Council here?
A. I've heard others talking about it, but I've never gone.

Q. Thank you for talking with me.
A. Thank you. It's not often someone sits down with me for this long of time. It's gets pretty lonely here. Come back again if you can.

During the interview you observe the following:

Dry lips and mouth
Flaky skin
Slight urine smell in the room
Drapes are closed

Very few personal belongings in room -- one picture of husband on dresser
Slight tremor in her hands
Dress is quite faded and has spots of dried food, sweater is out of shape and buttons buttoned unevenly. She is not wearing stockings, bra or slip
Wearing bedroom slippers
Undershirt showing at neckline
Facial hair evident
Nails dirty and untrimmed

Dresser cluttered with towels, wash cloths, bed pads, paper cup containing some cloudy fluid. Large discolored spot on privacy curtain, which has hooks missing.

Medical Record Review

Admitting Diagnoses

Arteriosclerotic heart disease
S/P CVA five months ago with minimal residual
Adult onset diabetes (1956)
Bilateral cataracts

Level of Care: Intermediate

Social History

Mrs. R had three children. One son was killed in a car accident in 1965. One daughter lives in another state. Another son lives with his family in the same city.

Her husband died 14 months ago after a short illness.

Her son decided she could no longer live alone in her home after the stroke. He sold her home (which was located in a town 200 miles away) and moved her to this nursing home because it was near his home. He visits every week or two, depending upon his travel schedule.

Activities

Activity progress notes written a month ago indicated that she refuses all group activities saying she is "too tired".

Dietary

Assessment includes diabetes, height 5'4", ideal body weight is 125 pounds, eats regular food, and has dentures.

Weight sheet shows 112 pounds recorded last month, 118 pounds recorded two months ago.

Progress notes written by nursing staff indicate that she often states she's not hungry at mealtime, can't chew meats well because of poorly fitting dentures, and requests smaller portions of food -- "give it to the men, they need it more". Two weeks ago the physician ordered ground meat per telephone order.

In the dining room you noted that she was seated at a table with residents in geri-chairs who frequently spilled their food, coughed food over the table and appeared confused. The residents were placed in the dining room at least a half hour before trays were served. When served, Mrs. R picked at her food; ate one bite of meat and vegetables, half of the jello fruit salad, and three-fourths of her dessert. She sat at the table until the nursing assistant asked if she was done. There was no encouragement for her to eat the rest of her food or to offer substitutes.

Medical

Physician's orders include:

Lanoxin 0.25 mg. qd.
Diabenese 250 mg. qd.
Lasix 40 mg. BID
Mom 30cc with Cascara 5cc prn
Metamucil one package daily
Fleets enema one if no BM for 3 days
Noctec 500 mg. po. HS. prn
Thyroid gr 1/2 gd.
ASA tab two every 4 hours, prn
Regular diet with ground meats

Physician's progress note written 45 days ago indicated she is doing well.

Nursing

Nurses' admission record includes the following information:

B/P -- 156/88 P -- 84 R -- 16 T -- 98.8
Height -- 5'4"

Weight -- 122 pounds, usual weight one year ago 145 pounds
S/P Hysterectomy 1952
T & A as child
Feeds self -- appetite poor
Continent
C/O some recent problems with constipation.
Has been using sleeping pills occasionally for past six months.
Two scabbed sores on left arm that she says she's had for awhile. Picks at them.
Large bruise on right leg. Says she bumped into edge of bed one night.
Vision -- poor
Hearing -- adequate

Multidisciplinary Plan (Dated as reviewed and revised five weeks ago; however no changes evident.)

Long Term Goal: Maintain Optimal Functioning

Problem/Need	Approach	Goal
Adjust to nursing home environment	Introduce her to roommate; Remind her of rules.	Maintain current level of functioning
	SW -- visit once a week for 15 minutes.	Adjust to nursing home
	Activity -- invite to all activities.	Increase socialization
	Dietary -- provide 1200 calorie diabetic diet.	Maintain current weight
Poor vision	Nursing -- assist with ADLs as necessary.	Maintain ADLs
	Eye appointment scheduled in three weeks.	Improve vision

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO 0938-

OBSERVATION / INTERVIEW RECORD REVIEW WORKSHEET

PROVIDER NUMBER

SURVEY DATE

OBSERVATION/INTERVIEW OF: (RESIDENT IDENTIFIES)

INSTRUCTIONS

1. Observe each resident in sample to identify ADL needs and potential problems. Check appropriate blocks
2. Interview only residents in sample who are capable and willing.
3. Review each resident's record to ensure assessments, plans, interventions and evaluations are appropriate and current.
4. Note deficiencies on survey report form after reviewing all residents in sample.

NURSING NEEDS

ADL'S
☐ Bathing
☐ Dressing
☐ Toileting
☐ Transferring
☐ Continence
☐ Feeding

SKIN
☐ Tears/Wounds
☐ Ulcers
☐ Rashes
☐ Flaking
☐ Scaling
☐ Red Area

DECUBITUS
☐ Grade
☐ Foul Odor
☐ Draining
☐ Dressing
☐ Unclean
☐ Not Dry
☐ Not Intact
☐ Poor Technique

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DRESSINGS
☐ Unclean
☐ Not Dry
☐ Not Intact
☐ Foul Odor
☐ Poor Technique

GROOMING/HYGIENE
☐ Eyes/Ears/Mouth
☐ Oral/Dental Hygiene
☐ Foot Care
☐ Facial Hair
☐ Hair/Scalp
☐ Nails
☐ Clothing
☐ Shoes/Slippers
☐ Odors

POSITIONING
☐ Contracted Extremities
☐ Improper Position
☐ No Protective Device
☐ ROM Improper
☐ Lack of Turning as Needed
☐ Schedule Not Present
☐ Improper Techniques
☐ Aseptic/Other

RESTRAINTS
☐ Type
☐ Inappropriate Application
☐ Improper Body Alignment/Support
☐ Not Released/Exercised Every 2 Hours
☐ Chemically Restrained

INJECTIONS
☐ Site Red/Swollen
☐ Improper Technique
☐ Resident Reacts

PARENTERAL FLUID/IV'S
☐ Rate Incorrect/Stopped
☐ Site Red/Swollen
☐ Dressing Unclean
☐ Unsafe Splint
☐ Improper Label
☐ Outdated Solution
☐ No I/O Recording

BOWEL/BLADDER
☐ Not Routinely Toileted
☐ Commode Not Available
☐ Schedule Not Available

CATHETER
☐ Inappropriate
☐ Poor Drainage
☐ Drainage System Open
☐ No Urine in Bag
☐ Urine Leaking
☐ Abdomen Distended
☐ Tubing Not Clean
☐ No Intake/Output Record
☐ Supply Storage Unclean

COLOSTOMY/ILEOSTOMY
☐ Not Well Regulated
☐ Odors
☐ Diarrhea/Constipation
☐ Site Red/Irritated

RESPIRATORY
☐ Congested/Short Breath
☐ IPPB Not Available
☐ Oxygen Not Available
☐ Improper Equipment Use

TRACHEOSTOMY
☐ Site Red/Swollen
☐ Obstructed
☐ Unclean
☐ Improper Suctioning
☐ Equipment Not Available

SUCTIONING
☐ Audible Rales
☐ Labored Breathing
☐ Drainage
☐ Equipment Not Available

DIETARY NEEDS
☐ Over/Under weight
☐ Dehydrated
☐ Edema
☐ Emaciated
☐ Dull/Dry Hair
☐ Swollen/Red Tongue
☐ Bleeding Gums
☐ Cracked Lips
☐ Inability to Chew
☐ Swallowing Problem
☐ Pallor

TUBE FEEDING
☐ Nutrition Inadequate
☐ Poorly Tolerated
☐ Vomits
☐ Dehydrated
☐ Over/Underweight
☐ Diarrhea/Constipation
☐ Poor Skin Condition
☐ Poor Mouth Condition
☐ Improper Technique

OTHER
☐
☐
☐
☐
☐

REHABILITATION NEEDS
☐ Cannot Communicate
☐ Ineffective Use of Assistive Device
☐ Improper Equipment Use
☐ Improper Technique
☐ Equipment Inadequate

SOCIAL SERVICE NEEDS
☐ Not Oriented
☐ Not Able to Converse
☐ Uncooperative/Disrupts
☐ Withdrawn
☐ Anxious
☐ Confused
☐ Lonely
☐ Vision/Hearing Needs
☐ Mentally Retarded

PATIENT RIGHTS
☐ Privacy Not Maintained
☐ Staff Not Courteous
☐ Not Informed of Rights
☐ Mental/Physical Abuse
☐ Cannot Exercise Rights
☐ Cannot Manage Affairs

ACTIVITY NEEDS
☐ Not Participating
☐ Vision/Hearing
☐ Chair/Bedfast
☐ Dependence/4 ADL's

NOTES:

RECORD REVIEW

☐ Drug Regimen Review (See SOM Appendix N Part 1).
☐ Satisfactory ☐ Unsatisfactory

ROUTINE REPORTS: ☐ Weights ☐ Lab ☐ X-ray ☐ Other

ASSESSMENT	PLAN	INTERVENTION	EVALUATION

PHYSICIAN SERVICES

☐ Admission Information
☐ Rehabilitation Information
☐ Physical Exam
☐ Written Care Plan
☐ Signs Orders/Notes
☐ Required Visits
☐ Emergency Availability
☐ Review of Care

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

OBSERVATION / INTERVIEW RECORD REVIEW WORKSHEET

PROVIDER NUMBER

SURVEY DATE

OBSERVATION/INTERVIEW OF: (RESIDENT IDENTIFIES)

INSTRUCTIONS

1. Observe each resident in sample to identify ADL needs and potential problems. Check appropriate blocks
2. Interview only residents in sample who are capable and willing.
3. Review each resident's record to ensure assessments, plans, interventions and evaluations are appropriate and current.
4. Note deficiencies on survey report form after reviewing all residents in sample.

NURSING NEEDS

ADL'S
- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Transferring
- ☐ Continence
- ☐ Feeding

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SKIN
- ☐ Tears/Wounds
- ☐ Ulcers
- ☐ Rashes
- ☐ Flaking
- ☐ Scaling
- ☐ Red Area

DECUBITUS
- ☐ Grade
- ☐ Foul Odor
- ☐ Draining
- ☐ Dressing
- ☐ Unclean
- ☐ Not Dry
- ☐ Not Intact
- ☐ Poor Technique

DRESSINGS
- ☐ Unclean
- ☐ Not Dry
- ☐ Not Intact
- ☐ Foul Odor
- ☐ Poor Technique

GROOMING/HYGIENE
- ☐ Eyes/Ears/Mouth
- ☐ Oral/Dental Hygiene
- ☐ Foot Care
- ☐ Facial Hair
- ☐ Hair/Scalp
- ☐ Nails
- ☐ Clothing
- ☐ Shoes/Slippers
- ☐ Odors

POSITIONING
- ☐ Contracted Extremities
- ☐ Improper Position
- ☐ No Protective Device
- ☐ ROM Improper
- ☐ Lack of Turning as Needed
- ☐ Schedule Not Present
- ☐ Improper Techniques
- ☐ Aseptic/Other

RESTRAINTS
- ☐ Type
- ☐ Inappropriate Application
- ☐ Improper Body Alignment/Support
- ☐ Not Released/Exercised Every 2 Hours
- ☐ Chemically Restrained

INJECTIONS
- ☐ Site Red/Swollen
- ☐ Improper Technique
- ☐ Resident Reacts

PARENTERAL FLUID/IV'S
- ☐ Rate Incorrect/Stopped
- ☐ Site Red/Swollen
- ☐ Dressing Unclean
- ☐ Unsafe Splint
- ☐ Improper Label
- ☐ Outdated Solution
- ☐ No I/O Recording

BOWEL/BLADDER
- ☐ Not Routinely Toileted
- ☐ Commode Not Available
- ☐ Schedule Not Available

CATHETER
- ☐ Inappropriate
- ☐ Poor Drainage
- ☐ Drainage System Open
- ☐ No Urine in Bag
- ☐ Urine Leaking
- ☐ Abdomen Distended
- ☐ Tubing Not Clean
- ☐ No Intake/Output Record
- ☐ Supply Storage Unclean

COLOSTOMY/ILEOSTOMY
- ☐ Not Well Regulated
- ☐ Odors
- ☐ Diarrhea/Constipation
- ☐ Site Red/Irritated

RESPIRATORY
- ☐ Congested/Short Breath
- ☐ IPPB Not Available
- ☐ Oxygen Not Available
- ☐ Improper Equipment Use

TRACHEOSTOMY
- ☐ Site Red/Swollen
- ☐ Obstructed
- ☐ Unclean
- ☐ Improper Suctioning
- ☐ Equipment Not Available

SUCTIONING
- ☐ Audible Rales
- ☐ Labored Breathing
- ☐ Drainage
- ☐ Equipment Not Available

DIETARY NEEDS
- ☐ Over/Under weight
- ☐ Dehydrated
- ☐ Edema
- ☐ Emaciated
- ☐ Dull/Dry Hair
- ☐ Swollen/Red Tongue
- ☐ Bleeding Gums
- ☐ Cracked Lips
- ☐ Inability to Chew
- ☐ Swallowing Problem
- ☐ Pallor

TUBE FEEDING
- ☐ Nutrition Inadequate
- ☐ Poorly Tolerated
- ☐ Vomits
- ☐ Dehydrated
- ☐ Over/Underweight
- ☐ Diarrhea/Constipation
- ☐ Poor Skin Condition
- ☐ Poor Mouth Condition
- ☐ Improper Technique

OTHER
- ☐
- ☐
- ☐
- ☐
- ☐

REHABILITATION NEEDS
- ☐ Cannot Communicate
- ☐ Ineffective Use of Assistive Device
- ☐ Improper Equipment Use
- ☐ Improper Technique
- ☐ Equipment Inadequate

SOCIAL SERVICE NEEDS
- ☐ Not Oriented
- ☐ Not Able to Converse
- ☐ Uncooperative/Disrupts
- ☐ Withdrawn
- ☐ Anxious
- ☐ Confused
- ☐ Lonely
- ☐ Vision/Hearing Needs
- ☐ Mentally Retarded

PATIENT RIGHTS
- ☐ Privacy Not Maintained
- ☐ Staff Not Courteous
- ☐ Not Informed of Rights
- ☐ Mental/Physical Abuse
- ☐ Cannot Exercise Rights
- ☐ Cannot Manage Affairs

ACTIVITY NEEDS
- ☐ Not Participating
- ☐ Vision/Hearing
- ☐ Chair/Bedfast
- ☐ Dependence/4 ADL's

NOTES:

Form HCFA-524 (11-85)

SEE REVERSE

RECORD REVIEW

☐ Drug Regimen Review (See SOM Appendix N Part 1).
☐ Satisfactory ☐ Unsatisfactory

ROUTINE REPORTS: ☐ Weights ☐ Lab ☐ X-ray ☐ Other

ASSESSMENT	PLAN	INTERVENTION	EVALUATION

PHYSICIAN SERVICES

☐ Admission Information

☐ Rehabilitation Information

☐ Physical Exam

☐ Written Care Plan

☐ Signs Orders/Notes

☐ Required Visits

☐ Emergency Availability

☐ Review of Care

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

RESIDENTS SELECTED FOR INDEPTH REVIEW

PROVIDER NUMBER

SURVEY DATE

	RESIDENT NAME (TARGETED)*	ROOM NUMBER	REASON FOR SELECTION
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

FORM HCFA-520 (11-85)

* NOTE IF ICF OR SNF RESIDENT

16

DINING AND EATING

OBJECTIVES

Dining and Eating Assistance Observation

At the completion of this session, each participant will be able to:

- Identify 5 examples of potential problems in dining and eating from a mock survey.
- Write 5 negative findings on the Dining and Eating Assistance Observation Worksheet.
- Document deficiencies on the Survey Report Form.

DINING AND EATING ASSISTANCE
OBSERVATION EXERCISE

October 23
12:00 Noon

1. Title slide.
2. Residents #1607 and #1612 -- Trays sitting 15 minutes in dining room.
3. Resident #1614 observed in hallway near nursing station. Tray sitting 15 minutes.
4. Residents #1605 and #1618 -- Trays sitting 15 minutes.
5. Residents #1601, #1608, #1619, and #1632 recently vacated dining table.
6. Resident #1625 -- Staff member says "hurry up, hurry up".

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

DINING ASSISTANCE WORKSHEET

PROVIDER NUMBER	SURVEY DATE

INSTRUCTIONS

TASKS 1. *Observe Dining Area*
2. *Note Meals Served Review Physicians Orders*
3. *Note Assistance Provided.*
4. *Note Deficiencies on Survey Summary Form.*

➤➤*SAMPLE A MINIMUM OF FIVE (5) RESIDENTS◀◀

1. DINING AREA AND MEALS

a. Size does not restrict movement.

b. Accommodate all patients.

c. Cleanliness.

d. Adequate/comfortable lighting.

e. Adequate/comfortable ventilation.

2

2. SERVING OF MEALS *

a. Number of meals/time span between meal.

b. Conformance to physicians order.

c. Nutritional adequate.

d. Adequacy of portions.

e. Residents eat approximately 75% of meals.

f. Puree dishes served individually.

g. Food cut, chopped or ground for individual resident needs.

h. Acceptable taste.

i. Proper temperature.

j. Plates covered.

FORM HCFA-523 (11-85)

SEE REVERSE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

2. SERVING OF MEALS **(continued)*

k. Served promptly.

l. Residents ready for meal when served.

m. Attractive.

n. Utensils available.

o. Functional trays for bedfast residents.

p. Salt, pepper, sugar, other condiments on resident's trays unless contraindicated.

q. Medically able residents eating in dining area.

r. Bedtime nourishment offered.

3 **3. SUPERVISION OF RESIDENT NUTRITION**

a. Prompt assistance.

b. Proper assistance (spoon-feeding; supervision or instruction to develop eating skills).

c. Courteous and unhurried assistance.

d. Self-help devices present (straws, easy grip utensils, special cup, etc.).

e. Intake recorded/deviations from normal are reported.

DEFICIENCY STATEMENT

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION: A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE

APPROVED BY STATE CERTIFYING AGENCY ☐ DISAPPROVED BY STATE CERTIFYING AGENCY ☐	REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	X6 DATE
APPROVED BY DHEW REGIONAL OFFICE ☐ DISAPPROVED BY DHEW REGIONAL OFFICE ☐ (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)	REVIEWED BY (INITIALS)	DATE	TITLE	

*Any deficiency statement ending with an asterisk (*) denotes a condition which the insitution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See cover sheet for further instructions.)

FORM SSA-2567 (11-75)

1. HEALTH INSURANCE REGIONAL OFFICE
OR OFFICE OF LONG-TERM CARE

Page ____ of ____

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION: A. BUILDING ____________ B. WING ____________	(X3) DATE SURVEY COMPLETED

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
2				

FORM **HCFA-2567A** (11-75) (FORMERLY SSA-2567A)

1. HEALTH INSURANCE REGIONAL OFFICE OR OFFICE OF LONG-TERM CARE

Page ____ of ____

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938

"MEDICARE/MEDICAID SKILLED NURSING FACILITY AND INTERMEDIATE CARE FACILITY SURVEY REPORT"

PROVIDER NUMBER	FACILITY NAME AND ADDRESS (City, State, Zip Code)
VENDOR NUMBER	
SURVEY DATE	

SURVEYORS' NAMES	TITLES

SURVEY TEAM COMPOSITION

Indicate the Number of Surveyors According to Discipline:

A. ☐ Administrator
B. ☐ Nurse
C. ☐ Dietitian
D. ☐ Pharmacist
E. ☐ Records Administrator
F. ☐ Social Worker
G. ☐ Qualified Mental Retardation Professional
H. ☐ Life Safety Code Specialist
I. ☐ Laboratorian
J. ☐ Sanitarian
K. ☐ Therapist
L. ☐ Physician
M. ☐ National Institute of Mental Health
N. ☐ Other

Note: More than one discipline may be marked for surveyors qualified in multiple disciplines.

Indicate the Total Number of Federal Surveyors Onsite: ________

(Continued on Reverse)

PROVIDER NUMBER: __________ PATIENT CENSUS: ☐ Medicare ☐ Medicaid ☐ Other Total Residents______

BATHING

___ Number of residents requiring assistance in bathing more than one part of body - or does not bathe self.

___ Number of residents requiring assistance in bathing only a single part (as back or disabled extremity) or bathes self completely.

___ Total*

DRESSING

___ Number of residents totally dressed by another person.

___ Number of residents needing assistance to dress self or remain partly dressed. (Exclude those residents totally dressed.)

___ Number of residents able to get clothes from closets and drawers - puts on clothes, outer garments, braces - manages fasteners - act of tying shoes is excluded.

___ Total*

TOILETING

___ Number of residents not toileted. (Use protective padding, catheter.)

___ Number of residents who must use bedpan or commode and/or receive assistance in getting to and using toilet.

___ Number of residents able to get to toilet - gets on and off toilet - cleans self - arranges clothes.

___ Total*

TRANSFERRING

___ Number of residents who need assistance in transferring to toilet and tub.

___ Number of residents who need assistance in moving in or out of bed and/or chair - (Exclude toilet, tub transfers).

___ Number of residents able to move in and out of bed independently and move in and out of chair independently - (may or may not be using mechanical supports).

___ Total*

CONTINENCE

___ Number of residents with indwelling or external catheters.

___ Number of residents with partial or total incontinence in urination or defecation - partial or total control by suppositories or enemas, regulated use of urinals and/or bed-pans.

___ Number of residents with urination and defecation entirely self-controlled.

___ Total*

FEEDING

___ Number of residents who receive nutrition parenteral feedings, e.g. tube, etc.

___ Number of residents who require assistance in act of eating.

___ Number of residents who get food from plate or its equivalent into mouth - (precutting of meat and preparation of food, as buttering bread, opening cartons, removing plate covers, etc., are excluded from evaluation).

___ Total*

---

* Must equal total number of residents in facility.

___ Number of completely bedfast residents.

___ Number of chairbound residents.

___ Number of ambulatory residents (may use cane, walker or crutches).

___ Number of restrained residents (belt, vest, cuffs).

___ Number of confused or disoriented residents.

___ Number of residents with Decubiti.

___ Number of residents on individually written bowel and bladder retraining program.

___ Number of residents receiving special skin care.

___ Number of residents receiving intravenous therapy and/or blood transfusion.

___ Number of residents requiring no assistance in ADLs.

___ Number of residents on self-administration of drugs.

FORM HCFA-519 (7/85)

NAME OF FACILITY

YES	NO	N/A	GOVERNING BODY	EXPLANATORY STATEMENTS
			SNF (405.1121) ☐ MET ☐ NOT MET	
			RESIDENT RIGHTS	
			SNF (405.1121(k)) ☐ MET ☐ NOT MET	
			[Indicators A thru L apply to SNFs.]	
			ICF (442.311) ☐ MET ☐ NOT MET	
			A. Information	
			1. The facility informs each resident, before or at the time of admission, of his rights and responsibilities.	
			2. The facility informs each resident, before or at the time of admission, of all rules governing resident conduct.	
			3. The facility informs each resident of amendments to their policies on residents' rights and responsibilities and rules governing conduct.	
			4. Each resident acknowledges in writing receipt of patients' rights information and any amendment to it.	
			5. The resident must be informed in writing of all services and charges for services.	
			6. The resident must be informed in writing of all changes in services and charges before or at the time of admission and on a continuing basis.	
			7. The resident must be informed of services not covered by Medicare or Medicaid and not covered in the basic rate.	
			B. Medical Condition and Treatment	
			1. Each resident is informed by a physician of his health and medical condition unless the physician decides that informing the resident is medically contraindicated.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			2. Each resident is given an opportunity to participate in planning his total care and medical treatment.	
			3. Each resident is given an opportunity to refuse treatment.	
			4. Each resident gives informed, written consent before participating in experimental research.	
			5. If the physician decides that informing the resident of his health and medical condition is medically contraindicated, the physician has documented this decision in the resident's medical record.	
			C. Transfer and Discharge	
			Each resident is transferred to discharged only for:	
			1. Medical reasons.	
			2. His/her welfare or that of other residents.	
			3. Nonpayment except as prohibited by the Medicare or Medicaid program.	
			D. Exercising Rights	
			1. Each resident is encouraged and assisted to exercise his/her rights as a resident of the facility and as a citizen.	
			2. Each resident is allowed to submit complaints and recommendations concerning the policies and services of the facility to staff or to outside representatives of the resident's choice or both.	
			3. Such complaints are submitted free from restraint, coercion, discrimination, or reprisal.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			E. Financial Affairs	
			1. Residents are allowed to manage their own personal financial affairs.	
			2. The facility establishes and maintains a system that assures full and complete accounting of residents' personal funds. An accounting report is made to each resident at least on a quarterly basis.	
			3. The facility does not commingle resident funds with any other funds other than patient funds.	
			4. If a resident requests assistance from the facility in managing his personal financial affairs, resident's delegation is in writing.	
			5. The facility system of accounting includes written receipts for:	
			All personnal possessions and funds received by or deposited with the facility.	
			All disbursements made to or for the resident.	
			6. The financial record must be available to the resident and his/her family.	
			F. Freedom from Abuse and Restraints	
			1. Each resident is free from mental and physical abuse.	
			2. Chemical and physical restraints are only used when authorized by a physician in writing for a specified period of time or in emergencies.	
			3. If used in emergencies, they are necessary to protect the resident from injury to himself or others.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			4. The use is authorized by a professional staff member identified in the written policies and procedures of the facility.	
			5. The use is reported promptly to the resident's physician by the staff member.	
			G. Privacy	
			1. Each resident is treated with respect, consideration and full recognition of his/her dignity and individuality.	
			2. Each resident is given privacy during treatment and care of personal needs.	
			3. Each resident's records, including information in an automatic data bank, are treated confidentially.	
			4. Each resident must give written consent before the facility releases information from his/her record to someone not otherwise authorized to receive it.	
			5. Married residents are given privacy during visits by their spouses.	
			6. Married residents are permitted to share a room.	
			H. Work	
			No resident may be required to perform services for the facility.	
			I. Freedom of Association and Correspondence	
			1. Each resident is allowed to communicate, associate and meet privately with individuals of his choice unless this infringes upon the rights of another resident.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			2. Each resident is allowed to send and receive personal mail unopened.	
			J. Activities Each resident is allowed to participate in social, religious, and community group activities.	
			K. Personal Possessions Each resident is allowed to retain and use his personal possessions and clothing as space permits.	
			L. Delegation of Rights and Responsibilities ICF 442.312 ☐ MET ☐ NOT MET	
			1. All the rights and responsibilities of a resident pass to the resident's guardian, next of kin or sponsoring agency or agencies if the resident is adjudicated incompetent under State law or is determined by his physician to be incapable of understanding his rights and responsibilities.	
			2. Physician determinations of incapability and the specific reasons thereof are recorded by the physician in the resident's record.	

NAME OF FACILITY

YES	NO	N/A	STATUS CHANGE NOTIFICATIONS	EXPLANATORY STATEMENTS
			SNF (405.1121(j)) ☐ MET ☐ NOT MET ICF (442.307) ☐ MET ☐ NOT MET	
			1. The facility notifies the resident's attending physician and other responsible persons in the event of an accident involving the resident, or other significant change in the resident's physical, mental, or emotional status, or patient charges, billings, and related administrative matters.	
			2. Except in a medical emergency, a resident is not transferred or discharged, nor is treatment altered radically, without consultation with the resident or, if the resident is incompetent, without prior notification of next of kin or sponsor.	

NAME OF FACILITY

YES | NO | N/A

PHYSICIANS' SERVICES

EXPLANATORY STATEMENTS

SNF (405.1123) ☐ MET ☐ NOT MET

A. Medical Findings and Orders at Time of Admission

SNF (405.1123(a)) ☐ MET ☐ NOT MET

1. There is made available to the facility prior to or at the time of admission, resident information which includes current medical findings, diagnoses, and orders from a physician for immediate care of the resident.

2. Information about the rehabilitation potential of the resident and a summary of prior treatment are made available to the facility at the time of admission or within 48 hours thereafter.

B. Resident Supervision by Physician

SNF (405.1123(b)) ☐ MET ☐ NOT MET

ICF (442.346) ☐ MET ☐ NOT MET

[Indicators B and C apply to ICFs.]

1. Every resident must be under the supervision of a physician.

2. A physician prescribes a planned regimen of care based on a medical evaluation of each resident's immediate and long-term care needs.

3. A physician is available to provide care in the absence of any resident's attending physician.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			4. Medical evaluation is done within 48 hours of admission unless done within 5 days prior to admission. Exception: Not required for ICF residents.	
			5. Each resident is seen by their attending physician at least once every 30 days for the first 90 days after admission. Exception: ICF Residents must be seen every 60 days unless otherwise justified and documented by the attending physician).	
			6. Each resident's total program of care including medications and treatments is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days and revised as necessary. Exception: Only medications must be reviewed quarterly for ICF Residents.	
			7. Progress notes are written and signed by the physician at the time of each visit, and all orders are signed by the physician. Exception: Not required for ICF residents.	
			8. Alternate physician visit schedules that exceed a 30-day schedule adopted after the 90th day following admission are justified by the attending physician in the medical record. These visits	

NAME OF FACILITY

YES | NO | N/A

cannot exceed 60 days or apply to patients who require specialized rehabilitation schedules.

Exception: ICF Residents must be seen every 60 days unless justified otherwise and documented by the attending physician.

C. Emergency Services

SNF (405.1123(c)) ☐ MET ☐ NOT MET

Emergency services from a physician are available and provided to each resident who requires emergency care.

EXPLANATORY STATEMENTS

NAME OF FACILITY

YES	NO	N/A	NURSING SERVICES	EXPLANATORY STATEMENTS
			SNF (405.1124) ☐ MET ☐ NOT MET	
			ICF (442.338) ☐ MET ☐ NOT MET	
			Indicators A thru E apply to ICFs except where noted.	
			A. The facility provides nursing services which are sufficient to meet nursing needs of all residents all hours of each day.	
			Indicators A and B apply to SNFs.	
			SNF (405.1124(c)) ☐ MET ☐ NOT MET	
			1. Each resident receives all treatments, medications and diet as prescribed. Deviations are reported and appropriate action is taken.	
			2. Each resident receives daily personal hygiene as needed to assure cleanliness, good skin care, good grooming, and oral hygiene taking into account individual preferences. Residents are encouraged to engage in self care activity.	
			3. Each resident receives care necessary to prevent skin breakdown.	
			4. Each resident with a decubitus receives care necessary to promote the healing of the decubitus including proper dressing.	
			5. When residents require restraints the application is ordered by the physician, applied properly, and released at least every 2 hours.	
			6. Each resident with incontinence is provided with care necessary to encourage continence including frequent toileting and opportunities for rehabilitative training.	

READEX FICHE

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			7. Each resident with a urinary catheter receives proper routine care including periodic evaluation.	
			8. Each resident receives proper care for the following needs: Injections Parenteral Fluids Colostomy/Ileostomy Respiratory Care Tracheostomy Care Suctioning Tube Feeding	
			9. Infection Control Techniques are properly carried out in the provision of care to each resident.	
			10. Proper nursing and sanitary procedures and techniques are used when medications are given to residents.	
			11. Adequate resident care supplies are available for providing treatments.	
			B. Twenty-Four Hour Nursing Service	
			1. Nursing personnel, including registered nurses, licensed practical (vocational) nurses, nurse aides, orderlies, and ward clerks, are assigned duties consistent with their education and experience, and based on the characteristics of the resident load.	
			2. Weekly time schedules are maintained and indicate the number and classifications of nursing personnel including relief personnel, who worked on each unit for each tour of duty.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

(If a distinct part certification, in an ICF or uncertified facility, show the staffing for the DP, and if appropriate, the entire facility and explain any sharing of nursing personnel.)

Exception: Not required for ICFs.

3. There is a sufficient number of nursing staff available to meet the total needs of all residents.

4. There is a registered nurse on the day tour of duty 7 days a week.

Exception: Not required for ICF residents.

C. Charge Nurse

SNF (405.1124(b)) ☐ MET ☐ NOT MET

1. A registered nurse or a qualified licensed practical (or vocational) nurse is designated as charge nurse by the director of nursing for each tour of duty.

Exception: Not required for ICFs.

2. The director of nursing services does not serve as charge nurse in a facility with an average daily total occupancy of 60 or more residents.

Exception: Not required for ICFs.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			LIST THE NUMBER OF FULL-TIME EQUIVALENTS OF RN'S, LPN'S, AIDES/ORDERLIES ASSIGNED TO NURSING DUTY FROM THE LAST 3 COMPLETE WEEKS. (NOTE ONLY ACTUAL STAFF ON DUTY.)	

SHIFT		DAY 1			DAY 2			DAY 3			DAY 4			DAY 5			DAY 6			DAY 7		
		RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DP	DAY																					
EN-TIRE FAC.																						
DP	EVEN-ING																					
EN-TIRE FAC.																						
DP	NIGHT																					
EN-TIRE FAC.																						

SHIFT		DAY 1			DAY 2			DAY 3			DAY 4			DAY 5			DAY 6			DAY 7		
		RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DP	DAY																					
EN-TIRE FAC.																						
DP	EVEN-ING																					
EN-TIRE FAC.																						
DP	NIGHT																					
EN-TIRE FAC.																						

NAME OF FACILITY

YES	NO	N/A

EXPLANATORY STATEMENTS

SHIFT		DAY 1			DAY 2			DAY 3			DAY 4			DAY 5			DAY 6			DAY 7		
		RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DP	DAY																					
ENTIRE FAC.																						
DP	EVENING																					
ENTIRE FAC.																						
DP	NIGHT																					
ENTIRE FAC.																						

STAFFING PATTERN WORKSHEETS DAY OF SURVEY (OPTIONAL)

ENTIRE FACILITY STAFFING PATTERN (DAY OF SURVEY)

		RN	PN	A
DAY	REPORT			
	ACTUAL			
EVENING	REPORT			
	ACTUAL			
NIGHT	REPORT			
	ACTUAL			

UNIT STAFFING PATTERN WORKSHEET (DAY OF SURVEY)

	UNIT ___			UNIT ___			UNIT ___			UNIT ___			UNIT ___		
	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DAY															
EVENING															
NIGHT															
CENSUS															

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			D. Rehabilitative Nursing Services are performed daily, and recorded for those residents who require such service. SNF (405.1124(e)) ☐ MET ☐ NOT MET 1. Each resident receives rehabilitative nursing care to promote maximum physical functioning to prevent immobility, deformities, and contractures. 2. There is an ongoing evaluation of each patient's rehabilitative nursing needs. This may include; (a) Range of motion, ambulation, turning and positioning and other activities; (b) Assistance and instruction in the activities of daily living such as feeding, dressing, grooming, oral hygiene and toilet activities; (c) Remotivation therapy and/or reality orientation when appropriate. 3. These activities are coordinated with other patient care services.	
			E. Awareness of nutritional needs and fluid intake of residents and prompt assistance where necessary in feeding residents. SNF (405.1124(f)) ☐ MET ☐ NOT MET 1. Each resident is provided with the amount of food and fluid on a daily basis necessary to maintain their appropriate minimum average weight. Between meal feedings are offered and the amount consumed is observed. Daily food and fluid intake is observed and encouraged.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

2. Each resident needing assistance in eating or drinking is provided prompt assistance. Specific self-help devices are available when necessary.

3. Deviations from normal food and fluid intake are recorded and reported to the charge nurse and the attending physician.

F. Administration of Drugs

SNF (405.1124(g)) ☐ MET ☐ NOT MET

ICF (442.337) ☐ MET ☐ NOT MET

1. The resident is identified prior to administration of a drug.

2. Drugs and biologicals are administered as soon as possible after doses are prepared.

3. Administered by same person who prepared the doses for administration except under single unit dose package distribution systems.

Exception: ICF residents may self administer medication with their physician's permission.

G. Conformance with Physician Drug Orders

SNF (405.1124(h)) ☐ MET ☐ NOT MET

ICF (442.334) ☐ MET ☐ NOT MET

Drugs are administered in accordance with written orders of the attending physician.

NAME OF FACILITY

YES	NO	N/A	DIETETIC SERVICES	EXPLANATORY STATEMENTS

SNF (405.1125) ☐ MET ☐ NOT MET

A. Menus and Nutritional Adequacy

SNF (405.1125(b)) ☐ MET ☐ NOT MET

ICF (442.332(a)(1)) ☐ MET ☐ NOT MET

Menus are planned and followed to meet the nutritional needs of each resident in accordance with physicians' orders and, to the extent medically possible, based on the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

B. Therapeutic Diets

SNF (405.1125(c)) ☐ MET ☐ NOT MET

ICF (442.332(b)(1)(2)) ☐ MET ☐ NOT MET

1. Therapeutic diets are prescribed by the attending physician.
2. Therapeutic menus are planned in writing, prepared, and served as ordered with supervision from the dietition and advice from the physician whenever necessary.

Number of Regular Diets

Number of Therapeutic Diets

Number of Mechanically Altered Diets

Number of Tube Feedings

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			C. Preparation	

SNF (405.1125(e)) ☐ MET ☐ NOT MET

ICF (442.332(a)(2)) ☐ MET ☐ NOT MET

1. Food is prepared by methods that conserve its nutritive value and flavor.
2. Meals are palatable, served at proper temperatures. They are cut, ground, chopped, pureed or in a form which meets individual resident needs.
3. If a resident refuses food served, appropriate substitutes of similar nutritive value are offered.

D. Frequency

SNF (405.1125.(d)) ☐ MET ☐ NOT MET

ICF (442.331(a)) ☐ MET ☐ NOT MET

1. At least three meals are served daily at regular hours with not more than a 14-hour span between a substantial evening meal and breakfast.
2. To the extent medically possible, bedtime nourishments are offered to all residents.

Exception: Not required for ICF residents.

N[illegible] FACILITY

YES	NO	N/A	E. Staffing	EXPLANATORY STATEMENTS
			SNF (405.1125.(a)) ☐ MET ☐ NOT MET Food service personnel are on duty daily over a period of 12 or more hours.	

NAME OF FACILITY

YES	NO	N/A	SPECIALIZED REHABILITATIVE SERVICES	EXPLANATORY STATEMENTS
			SNF (405.1126) ☐ MET ☐ NOT MET	
			SNF (405.1126(b)) ☐ MET ☐ NOT MET Indicators A thru C apply to SNFs.	
			A. Plan of Care ICF (442.343(e)(1)(2)) ☐ MET ☐ NOT MET Rehabilitative services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapists(s) and the nursing service.	
			B. Therapy ICF (442.343(a)(c)(d)) ☐ MET ☐ NOT MET Therapy is provided according to orders of the attending physician in accordance with accepted professional practices by qualified therapists or qualified assistants.	
			C. Progress ICF (442.343(f)) ☐ MET ☐ NOT MET 1. A report of the patient's progress is communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services. Exception: ICF resident's progress must be reviewed regularly.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			2. The patient's progress is thereafter reviewed regularly, and the plan of rehabilitative care is reevaluated as necessary, but at least every 30 days, by the physician and the therapist. Exceptions: ICF residents' plans must be revised as necessary.	

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

PHARMACEUTICAL SERVICES

SNF (405.1127) ☐ MET ☐ NOT MET

A. Supervision

SNF (405.1127(a)) ☐ MET ☐ NOT MET

ICF (442.336(a)(b)) ☐ MET ☐ NOT MET

The pharmacist reviews the drug regimen of each patient at least monthly and reports any irregularities to the medical director and administrator.

Exception: A registered nurse may be utilized to perform this review for ICF residents. Also, the attending or staff physician must review medications quarterly.

B. Labeling of Drugs and Biologicals

SNF (405.1127(c)) ☐ MET ☐ NOT MET

ICF (442.333(a)) ☐ MET ☐ NOT MET

The labeling of drugs and biologicals is based on currently accepted professional principles and includes the appropriate accessary and cautionary instructions as well as an expiration date when applicable.

NAME OF FACILITY

YES	NO	N/A	LABORATORY AND RADIOLOGIC SERVICES	EXPLANATORY STATEMENTS
			SNF (405.1128) ☐ MET ☐ NOT MET	
			SNF (405.1128(a)) ☐ MET ☐ NOT MET	
			A. Provision of Services	
			1. All services are provided only on the orders of a physician.	
			2. The attending physician is notified promptly of diagnostic findings.	
			3. Signed and dated reports of a clinical laboratory, X-ray and other diagnostic services are filed with the patient's medical record.	

NAME OF FACILITY

YES	NO	N/A	SOCIAL SERVICES	EXPLANATORY STATEMENTS
			SNF (405.1130) ☐ MET ☐ NOT MET	
			SNF (405.1130)(a)) ☐ MET ☐ NOT MET Indicators A and B apply to SNFs.	
			A. Plan ICF (442.344(d)) ☐ MET ☐ NOT MET The medically related social and emotional needs of the resident are identified.	
			b. Provision of Services ICF (442.344(a)(b)) ☐ MET ☐ NOT MET 1. Services are provided to meet the social and emotional needs by the facility or by referral to appropriate social agencies. 2. If financial assistance is indicated, arrangements are made promptly for referral to an appropriate agency.	

NAME OF FACILITY

YES	NO	N/A	ACTIVITIES			EXPLANATORY STATEMENTS
			SNF (405.1131)	☐ MET	☐ NOT MET	
			A. Provision of Services			
			SNF (405.1131(b))	☐ MET	☐ NOT MET	
			ICF (442.345(a)(c)(d))	☐ MET	☐ NOT MET	
			1. An ongoing program of meaningful activities is provided based on identified needs and interests of each resident. It is designed to promote opportunities for engaging in normal pursuits, including religious activities of their choice, if any.			
			2. Unless contraindicated by the attending physicians all residents are encouraged to participate in activities program.			
			3. The activities promote the physical, social and mental well-being of the residents.			
			4. Equipment is maintained in good working order.			
			5. Supplies and equipment are available.			

NAME OF FACILITY

YES	NO	N/A	PATIENT CARE MANAGEMENT	EXPLANATORY STATEMENTS
			SNF (405.1124(d)) ☐ MET ☐ NOT MET ICF (442.341) ☐ MET ☐ NOT MET A. Each resident's needs are addressed in a written plan of care which demonstrates that the plans of all services are integrated, consonant with the physician's plan of medical care, and is implemented shortly after admission. B. Each professional service identifies needs, goals, plans, and evaluates the effectiveness of interventions, plus institutes changes in the plan of care in a timely manner.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			TRAINING	

SNF (405.1121(h) ☐ MET ☐ NOT MET

ICF (442.314) ☐ MET ☐ NOT MET

1. Facility staff are knowledgeable about the problems and needs of the aged, ill, and disabled.
2. Facility staff practice proper techniques in providing care to the aged, ill, and disabled.
3. Facility staff practice proper technique for prevention and control of infection, fire prevention and safety, accident prevention, confidentiality of resident information, and preservation of resident dignity, including protection of privacy and personal and property rights.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			MEDICAL RECORDS	
			SNF (405.1132) ☐ MET ☐ NOT MET	
			Content	
			SNF (405.1132(c)) ☐ MET ☐ NOT MET	
			ICF (442.318(a)(c)) ☐ MET ☐ NOT MET	
			1. The medical record contains sufficient information to identify the resident clearly, to justify diagnoses and treatment, and to document results accurately.	
			2. The medical record contains the following information.	
			a. Identification information	
			b. Admission data including past medical and social history	
			c. Transfer form, discharge summary from any transferring facility	
			d. Report of resident's attending physician	
			e. Report of physical examinations	
			f. Reports of physicians' periodic evaluations and progress notes	
			g. Diagnostic reports and therapeutic orders	
			h. Reports of treatments	
			i. Medications administered	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			j. An overall plan of care setting forth goals to be accomplished through each service's designed activities, therapies and treatments	
			k. Assessments and goals of each service's plan of care	
			l. Treatments and services rendered	
			m. Progress notes	
			n. All symptoms and other indications of illness or injury including date, time and action taken regarding each problem.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			TRANSFER AGREEMENT	
			SNF (405.1133) ☐ MET ☐ NOT MET	
			SNF (405.1133(a)) ☐ MET ☐ NOT MET	
			ICF (442.316) ☐ MET ☐ NOT MET	
			A. Whenever the attending physician determines that a transfer is medically appropriate between a hospital or a facility providing more specialized care and the nursing facility, admission to the new facility shall be effected in a timely manner.	
			B. Information necessary for providing care and treatment to transferred individuals is provided.	

NAME OF FACILITY

YES	NO	N/A	PHYSICAL ENVIRONMENT	EXPLANATORY STATEMENTS
			SNF (405.1134) ☐ MET ☐ NOT MET	
			A. Nursing Unit:	
			SNF (405.1134(d)) ☐ MET ☐ NOT MET	
			1. The unit is properly equipped for preparation and storage of drugs and biologicals. 2. There is adequate space for utility and storage. 3. The unit is equipped to register resident calls with a functioning communication system from resident areas including resident rooms and toilet and bathing facilities.	
			B. Dining and Activities Area:	
			SNF (405.1134(g)) ☐ MET ☐ NOT MET	
			ICF (442.329) ☐ MET ☐ NOT MET	
			1. The facility provides one or more clean, orderly and appropriately furnished rooms of adequate size, designated for resident dining and resident activities. 2. Dining and activity rooms are well lighted and ventilated. 3. Any multipurpose room used for dining and resident activities has sufficient space to accommodate all activities and prevent their interference with each other.	

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

SNF (405.1134(e)) ☐ MET ☐ NOT MET

Indicators C and D apply to SNFs.

C. Resident Rooms:

ICF (442.325) ☐ MET ☐ NOT MET

1. Single resident rooms have at least 100 square feet.
2. Multiple resident rooms have no more than four residents and at least 80 square feet per resident.
3. Each room is equipped with or conveniently located near toilet and bathing facilities.
4. There is capability of maintaining privacy in each.
5. There is adequate storage space for each resident.
6. There is a comfortable and functioning bed and chair plus a functioning cabinet and light.
7. Personal expression is allowed.
8. The resident call system functions in resident rooms.
9. Each room is designed and equipped for adequate nursing care and the comfort and privacy of the residents.
10. Each room is at or above grade level.
11. Each room has direct access to a corridor and outside exposure.

Exception: Not required for ICF residents.

D. Toilet and Bath Facilities

ICF (442.326) ☐ MET ☐ NOT MET

1. Facilities are clean, sanitary and free of odors.
2. Facilities have safe and comfortable hot water temperatures.
3. Facilities have capability of maintaining privacy.
4. Facilities have grab bars and other safeguards against slipping.
5. Facilities have fixtures in good condition.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			E. Social Service Area: SNF (405.1130(b)) ☐ MET ☐ NOT MET ICF (442.344(c)) ☐ MET ☐ NOT MET 1. Capability to ensure privacy for social service interviewing. 2. Adequate space for clerical and interviewing functions. 3. Easily accessible to residents and staff.	
			F. Therapy Areas: SNF (405.1126(a)) ☐ MET ☐ NOT MET ICF (442.328(a)) ☐ MET ☐ NOT MET 1. Space is adequate for proper use of equipment by all residents receiving treatments. 2. Equipment is safe and in proper working condition.	
			G. Facilities for Special Care SNF (405.1134(f)) ☐ MET ☐ NOT MET ICF (442.328(b)) ☐ MET ☐ NOT MET 1. Single rooms with private toilet and handwashing facilities are available for isolating residents. 2. Precautionary signs are used to identify these rooms when in use.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

ICF (442.324) ☐ MET ☐ NOT MET

Indicators H and I apply to ICFs.

H. Common Resident Areas:

SNF (405.1134(j)) ☐ MET ☐ NOT MET

1. All common resident areas are clean, sanitary and free of odors.
2. Provision is made for adequate and comfortable lighting levels in all areas.
3. There is limitation of sounds at comfort levels.
4. A comfortable room temperature is maintained.
5. Adequate ventilation through windows or mechanical means or a combination of both.
6. Corridors are equipped with firmly secured handrails on each side.
7. Staff are aware of procedures to ensure water to all essential areas in the event of loss of normal supply.

I. Maintenance of Building and Equipment:

SNF (405.1134(i)) ☐ MET ☐ NOT MET

1. The interior and exterior of the building are clean and orderly.
2. All essential mechanical and electrical equipment is maintained in safe operating condition.
3. Sufficient storage space is available and used for equipment to ensure that the facility is orderly and safe.
4. Resident care equipment is clean and maintained in safe operating condition.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

ICF (442.331) ☐ MET ☐ NOT MET

Indicators J and K apply to ICFs.

J. Dietetic Service Area:

SNF (405.1134(h)) ☐ MET ☐ NOT MET

1. Kitchen and dietetic service areas are adequate to insure proper, timely food services for all patients.
2. Kitchen areas are properly ventilated, arranged, and equipped for storage and preparation of food as well as for dish and utensil cleaning, and refuse storage and removal.

K. Dietetic Sanitary Conditions

SNF (405.1125(f)(g)) ☐ MET ☐ NOT MET

1. Dietetic service personnel practice hygienic food handling techniques.
2. Food is stored, refrigerated, prepared, distributed, and served under sanitary conditions.
3. Waste is disposed of properly.

L. Emergency Power

SNF (405.1134(b)) ☐ MET ☐ NOT MET

1. An emergency source of electrical power necessary to protect the health and safety of residents is available in the event the normal electrical supply is interrupted.
2. Emergency power is adequate at least for lighting in all means of egress; equipment to maintain fire detection, alarm, and extinguishing systems; and life safety support systems.
3. Emergency power is provided by an emergency electrical generator located on the premises where life support systems are used.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			INFECTION CONTROL SNF (405.1135) ☐ MET ☐ NOT MET	
			A. Infection Control SNF (405.1135(b)) ☐ MET ☐ NOT MET Aseptic and isolation techniques are followed by all personnel.	
			B. Sanitation SNF (405.1135(c)) ☐ MET ☐ NOT MET The facility maintains a safe, clean, and orderly interior.	
			C. Linen SNF (405.1135(d)) ☐ MET ☐ NOT MET 1. The facility has available at all times a quantity of linen essential for proper care and comfort of residents. 2. Linens are handled; stored, processed, and transported in such a manner as to prevent the spread of infection.	
			D. Pest Control SNF (405.1135(e)) ☐ MET ☐ NOT MET The facility is maintained free from insects and rodents.	

NAME OF FACILITY

YES	NO	N/A	DISASTER PREPAREDNESS	EXPLANATORY STATEMENTS
			SNF (405.1136) ☐ MET ☐ NOT MET	
			SNF (405.1136(a)) ☐ MET ☐ NOT MET	
			ICF (442.313) ☐ MET ☐ NOT MET	
			Indicators A and B apply to ICFs.	
			A. Disaster Plan	
			1. Facility staff are aware of plans, procedures to be followed for fire, explosion or other disaster.	
			2. Facility staff are knowledgeable about evacuation routes.	
			3. Facility staff are aware of their specific responsibilities in regard to evaluation and protection of residents.	
			4. Facility staff are aware of methods of containing fire.	
			B. Drills	
			SNF (405.1136(b)) ☐ MET ☐ NOT MET	
			1. All employees are trained, as part of their employment orientation in all aspects of preparedness for any disaster.	
			2. Facility staff participate in ongoing training and drills in all procedures so that each employee promptly and correctly carries out a specific role in case of a disaster.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

TOUR NOTES WORKSHEET

PROVIDER NUMBER

SURVEY DATE

INSTRUCTIONS

1. *Note care and problems in care on all units.*
2. *Report deficiencies directly to survey report form or evaluate further during indepth sample review.*
3. *Select residents for indepth review.*
4. *Select a proportionate number from each section.*

INDEPTH SAMPLE

Facility Bed Size	*<60*	*60-200*	*200+*
Sample Size	*5*	*10%*	*30*

OBSERVE RESIDENTS FOR THE FOLLOWING CARE PROBLEMS

GROOMING/PERSONAL HYGIENE

POSITIONING

ASSISTIVE DEVICES

AMBULATION

RESTRAINTS

HYDRATION

INFECTION CONTROL

PATIENT RIGHTS

OTHER

FORM HCFA-521 (11-85)

RTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

RESIDENTS SELECTED FOR INDEPTH REVIEW

PROVIDER NUMBER

SURVEY DATE

	RESIDENT NAME (TARGETED)*	ROOM NUMBER	REASON FOR SELECTION
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

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FORM HCFA-520 (11-85)

* NOTE IF ICF OR SNF RESIDENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

DRUG PASS WORKSHEET

PROVIDER NUMBER

SURVEY DATE

ERROR RATE ☐

INSTRUCTIONS

1. *Perform Drug Pass Observations on 20 Residents.*
2. *Record Observation of each Opportunity.*
3. *Compare Observation Notes with Physician Orders.*
4. *Calculate and Note Error Rate.*
5. *Note Defeciencies on Survey Report Form.*

DEFICIENCY FORMULA

1. *One or more Significant Errors = Deficiency*
2. $\frac{\text{Significant + Non-significant}}{\text{Doses Given + Doses Ordered But Not Given}} \times 100 \quad \geq 5\% = \text{Deficiency}$

IDENTIFIER	POUR	PASS	RECORD
RESIDENTS FULL NAME, ROOM NUMBER, TIME	DRUG PRESCRIPTION NAME, DOSE AND FORM	OBSERVATION OF ADMINISTRATION	DRUG ORDER WRITTEN AS: *(IF DIFFERS FROM ADMINIS ONLY)*

FORM HCFA-522 (11-85)

DRUG ERROR CALCULATION
(page 10-11 SOM excerpt)

How to Calculate a Medication Error Rate—In calculating the percentage of errors, the numerrator in the ratio is the total number of errors that you observe, both significant and non-significant. The denominator is all the doses you observed being administered **plus** the doses ordered but not administered. The equation for calculating a medication error rate is as follows:

$$\text{Medication Error Rate} = \frac{\text{Number of errors observed}}{\text{Opportunities for errors}} \times 100$$

Where: Opportunities for errors equals the number of doses administered **plus** the number of doses ordered but not administered.

Comments

For example, you observed the administration of drugs to 20 patients. There were a total of 47 drugs administered (47 opportunities for errors). At the completion of the reconciliation of your Observations with the physicians' orders, you find that three medication errors were made in administration and one medication was omitted (ordered but not administered). The omitted dose is included in both the numerator and the denominator. Therefore, following the above formula, your equation would be as follows:

$$\frac{3 + 1}{47 + 1} \times 100 = 8.3\%$$

ENT OF HEALTH AND HUMAN SERVICES
CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

DINING ASSISTANCE WORKSHEET

PROVIDER NUMBER

SURVEY DATE

INSTRUCTIONS

TASKS 1. Observe Dining Area.
2. Note Meals Served/Review Physicians Orders.
3. Note Assistance Provided.
4. Note Deficiencies on Survey Summary Form.

▶▶*SAMPLE A MINIMUM OF FIVE (5) RESIDENTS◀◀

1. DINING AREA AND MEALS

a. Size does not restrict movement.

b. Accommodate all patients.

c. Cleanliness.

d. Adequate/comfortable lighting.

e. Adequate/comfortable ventilation.

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2. SERVING OF MEALS *

a. Number of meals/time span between meal.

b. Conformance to physicians order.

c. Nutritional adequate.

d. Adequacy of portions.

e. Residents eat approximately 75% of meals.

f. Puree dishes served individually.

g. Food cut, chopped or ground for individual resident needs.

h. Acceptable taste.

i. Proper temperature.

j. Plates covered.

FORM HCFA-523 (11-85)

SEE REVERSE

2. SERVING OF MEALS *(*continued*)

k. Served promptly.

l. Residents ready for meal when served.

m. Attractive.

n. Utensils available.

o. Functional trays for bedfast residents.

p. Salt, pepper, sugar, other condiments on resident's trays unless contraindicated.

q. Medically able residents eating in dining area.

r. Bedtime nourishment offered.

3. SUPERVISION OF RESIDENT NUTRITION

a. Prompt assistance.

b. Proper assistance (spoon-feeding; supervision or instruction to develop eating skills).

c. Courteous and unhurried assistance.

d. Self-help devices present (straws, easy grip utensils, special cup, etc.).

e. Intake recorded/deviations from normal are reported.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO 0938-

OBSERVATION / INTERVIEW RECORD REVIEW WORKSHEET

PROVIDER NUMBER

SURVEY DATE

OBSERVATION/INTERVIEW OF: (RESIDENT IDENTIFIES)

INSTRUCTIONS

1. Observe each resident in sample to identify ADL needs and potential problems. Check appropriate blocks
2. Interview only residents in sample who are capable and willing.
3. Review each resident's record to ensure assessments, plans, interventions and evaluations are appropriate and current.
4. Note deficiencies on survey report form after reviewing all residents in sample.

NURSING NEEDS

ADL'S
- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Transferring
- ☐ Continence
- ☐ Feeding

SKIN
- ☐ Tears/Wounds
- ☐ Ulcers
- ☐ Rashes
- ☐ Flaking
- ☐ Scaling
- ☐ Red Area

DECUBITUS
- ☐ Grade
- ☐ Foul Odor
- ☐ Draining
- ☐ Dressing
- ☐ Unclean
- ☐ Not Dry
- ☐ Not Intact
- ☐ Poor Technique

DRESSINGS
- ☐ Unclean
- ☐ Not Dry
- ☐ Not Intact
- ☐ Foul Odor
- ☐ Poor Technique

GROOMING/HYGIENE
- ☐ Eyes/Ears/Mouth
- ☐ Oral/Dental Hygiene
- ☐ Foot Care
- ☐ Facial Hair
- ☐ Hair/Scalp
- ☐ Nails
- ☐ Clothing
- ☐ Shoes/Slippers
- ☐ Odors

POSITIONING
- ☐ Contracted Extremities
- ☐ Improper Position
- ☐ No Protective Device
- ☐ ROM Improper
- ☐ Lack of Turning as Needed
- ☐ Schedule Not Present
- ☐ Improper Techniques
- ☐ Aseptic/Other

RESTRAINTS
- ☐ Type
- ☐ Inappropriate Application
- ☐ Improper Body Alignment/Support
- ☐ Not Released/Exercised Every 2 Hours
- ☐ Chemically Restrained

INJECTIONS
- ☐ Site Red/Swollen
- ☐ Improper Technique
- ☐ Resident Reacts

PARENTERAL FLUID/IV'S
- ☐ Rate Incorrect/Stopped
- ☐ Site Red/Swollen
- ☐ Dressing Unclean
- ☐ Unsafe Splint
- ☐ Improper Label
- ☐ Outdated Solution
- ☐ No I/O Recording

BOWEL/BLADDER
- ☐ Not Routinely Toileted
- ☐ Commode Not Available
- ☐ Schedule Not Available

CATHETER
- ☐ Inappropriate
- ☐ Poor Drainage
- ☐ Drainage System Open
- ☐ No Urine in Bag
- ☐ Urine Leaking
- ☐ Abdomen Distended
- ☐ Tubing Not Clean
- ☐ No Intake/Output Record
- ☐ Supply Storage Unclean

COLOSTOMY/ILEOSTOMY
- ☐ Not Well Regulated
- ☐ Odors
- ☐ Diarrhea/Constipation
- ☐ Site Red/Irritated

RESPIRATORY
- ☐ Congested/Short Breath
- ☐ IPPB Not Available
- ☐ Oxygen Not Available
- ☐ Improper Equipment Use

TRACHEOSTOMY
- ☐ Site Red/Swollen
- ☐ Obstructed
- ☐ Unclean
- ☐ Improper Suctioning
- ☐ Equipment Not Available

SUCTIONING
- ☐ Audible Rales
- ☐ Labored Breathing
- ☐ Drainage
- ☐ Equipment Not Available

DIETARY NEEDS
- ☐ Over/Under weight
- ☐ Dehydrated
- ☐ Edema
- ☐ Emaciated
- ☐ Dull/Dry Hair
- ☐ Swollen/Red Tongue
- ☐ Bleeding Gums
- ☐ Cracked Lips
- ☐ Inability to Chew
- ☐ Swallowing Problem
- ☐ Pallor

TUBE FEEDING
- ☐ Nutrition Inadequate
- ☐ Poorly Tolerated
- ☐ Vomits
- ☐ Dehydrated
- ☐ Over/Underweight
- ☐ Diarrhea/Constipation
- ☐ Poor Skin Condition
- ☐ Poor Mouth Condition
- ☐ Improper Technique

OTHER
- ☐
- ☐
- ☐
- ☐
- ☐

REHABILITATION NEEDS
- ☐ Cannot Communicate
- ☐ Ineffective Use of Assistive Device
- ☐ Improper Equipment Use
- ☐ Improper Technique
- ☐ Equipment Inadequate

SOCIAL SERVICE NEEDS
- ☐ Not Oriented
- ☐ Not Able to Converse
- ☐ Uncooperative/Disrupts
- ☐ Withdrawn
- ☐ Anxious
- ☐ Confused
- ☐ Lonely
- ☐ Vision/Hearing Needs
- ☐ Mentally Retarded

PATIENT RIGHTS
- ☐ Privacy Not Maintained
- ☐ Staff Not Courteous
- ☐ Not Informed of Rights
- ☐ Mental/Physical Abuse
- ☐ Cannot Exercise Rights
- ☐ Cannot Manage Affairs

ACTIVITY NEEDS
- ☐ Not Participating
- ☐ Vision/Hearing
- ☐ Chair/Bedfast
- ☐ Dependence/4 ADL's

NOTES:

SEE REVERSE

RECORD REVIEW

☐ Drug Regimen Review (See SOM Appendix N Part 1). ☐ Satisfactory ☐ Unsatisfactory	ROUTINE REPORTS: ☐ Weights ☐ Lab ☐ X-ray ☐ Other

ASSESSMENT	PLAN	INTERVENTION	EVALUATION

PHYSICIAN SERVICES

☐ Admission Information

☐ Rehabilitation Information

☐ Physical Exam

☐ Written Care Plan

☐ Signs Orders/Notes

☐ Required Visits

☐ Emergency Availability

☐ Review of Care

PART A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-

PART A — ADMINISTRATIVE AND PROCEDURAL REQUIREMENTS

MEDICARE / MEDICAID SKILLED NURSING FACILITY AND INTERMEDIATE CARE FACILITY SURVEY REPORT

PROVIDER NUMBER

VENDOR NUMBER

SURVEY DATE

FACILITY NAME AND ADDRESS (*City, State, Zip Code*)

SURVEYORS' NAMES	TITLES

NAME OF FACILITY

YES	NO	N/A	COMPLIANCE WITH STATE AND LOCAL LAWS (Condition of Participation)	EXPLANATORY STATEMENTS
			SNF (405.1120) ☐ MET ☐ NOT MET	
			A. Licensure	
			SNF (405.1120(a)) ☐ MET ☐ NOT MET	
			ICF (442.251) ☐ MET ☐ NOT MET	
			The facility has a current State License (Number ______)	
			B. Personnel Licensure	
			SNF (405.1120(b)) ☐ MET ☐ NOT MET	
			ICF (442.302) ☐ MET ☐ NOT MET	
			Staff of the facility are licensed or registered in accordance with applicable State laws.	
			C. Compliance with Other Laws	
			SNF (405.1120(c)) ☐ MET ☐ NOT MET	
			ICF (442.252) ☐ MET ☐ NOT MET	
			ICF (442.315) ☐ MET ☐ NOT MET	
			The facility is in compliance with applicable Federal, State and local laws and regulations relating to fire and safety, sanitation, communicable and reportable diseases, postmortem procedures and other relevant health and safety requirements.	
			The facility is in compliance with applicable regulations pertaining to:	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			Buying, dispensing, safeguarding, administering, and disposing of medications and controlled substances.	
			Exception: Not applicable to SNFs.	
			Construction, maintenance and equipment.	
			Exception: Not applicable to SNFs.	
			Current reports from all responsible governmental agencies are retained at the facility.	
			GOVERNING BODY AND MANAGEMENT (Condition of Participation)	
			SNF (405.1121) ☐ MET ☐ NOT MET	
			The facility has a governing body with full legal authority and responsibility for operation of the facility.	
			A. Disclosure	
			SNF (405.1121(a)) ☐ MET ☐ NOT MET	
			Full disclosure of ownership has been made in accordance with requirements at 42 CFR 420.206.	
			B. Administration	
			SNF (405.1121(c)) ☐ MET ☐ NOT MET	
			1. Written bylaws address the operation of the facility.	
			2. Written bylaws and policies address effective resident care.	
			3. Bylaws are reviewed and revised as necessary.	

NAME OF FACILITY ______________________

YES	NO	N/A		EXPLANATORY STATEMENTS
			ICF (442.301) ☐ MET ☐ NOT MET The facility has methods of administrative management which govern the overall operation of the facility.	
			C. Independent Medical Review SNF (405.1121(d)) ☐ MET ☐ NOT MET The facility has policies which ensure that the facility cooperates in an effective program for regular independent medical evaluation and audit of residents in the facility to the extent required by the programs in which the facility participates.	
			D. Administrator SNF (405.1121(e)) ☐ MET ☐ NOT MET ICF (442.303) ☐ MET ☐ NOT MET The facility has a licensed administrator who has authority for the overall operation of the facility. (Administrator's license or registration number ____________________).	
			E. Resident Care Director ICF (442.304) ☐ MET ☐ NOT MET 1. The administrator or another professional staff member is the resident care director (RSD). 2. The RSD coordinates and monitors each resident's care.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

F. Institutional Planning

SNF (405.1121(f)) ☐ MET ☐ NOT MET

1. The facility has an overall plan and budget prepared by a committee of representatives from the governing body, administrative staff, and the organized medical staff (if any).

2. The overall plan and budget is reviewed and updated at least annually.

3. The plan includes a capital expenditures plan, if necessary.

G. Personnel Policies and Procedures

SNF (405.1121(g)) ☐ MET ☐ NOT MET

1. The facility has written policies and procedures that support sound resident care and personnel practices and address, at least:

   a. Control of communicable disease;

   b. The review of employee incidents and accidents to identify health and safety hazards; and

   c. The existence of a safe and sanitary environment.

2. Personnel records are current, available to each employee, and contain sufficient information to support placement in the position to which assigned.

3. Referral or provision for periodic health examinations to ensure freedom from communicable disease.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			H. Outside Resources/Consultant Agreements SNF (405.1121(i)) ☐ MET ☐ NOT MET ICF (442.317) ☐ MET ☐ NOT MET The facility has written agreements with qualified persons to render a service (if it does not employ a qualified professional person to do so). The agreements: 1. Address the responsibilities, functions, objectives, and terms (including financial arrangements and charges); 2. Are signed by an authorized representative of the facility and the outside resource; and 3. Specify that the facility retains ultimate responsibility for the services rendered.	
			I. Notification of Change in Resident Status SNF (405.1121(j)) ☐ MET ☐ NOT MET The facility has policies and procedures to notify physicians and other responsible persons in the event of an accident involving the resident, or resident's physical, mental or emotional status, or resident charges, billings or related administrative matters.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			J. Resident Rights	
			SNF (405.1121(k)) ☐ MET ☐ NOT MET	
			Indicators 1 thru 12 apply to SNFs.	
			ICF (442.311) ☐ MET ☐ NOT MET	
			1. Information	
			a. The facility informs each resident, before or at the time of admission, of his rights and responsibilities.	
			b. The facility informs each resident, before or at the time of admission, of all rules governing resident conduct.	
			c. The facility informs each resident of amendments to their policies on residents' rights and responsibilities and rules governing conduct.	
			d. Each resident acknowledges in writing receipt of patients' rights information and any amendment to it.	
			e. The resident must be informed in writing of all services and charges for services.	
			f. The resident must be informed in writing of all changes in services and charges before or at the time of admission and on a continuing basis.	
			g. The resident must be informed of services not covered by Medicare or Medicaid and not covered in the basic rate.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			2. Medical Condition and Treatment	
			a. Each resident is informed by a physician of his health and medical condition unless the physician decides that informing the resident is medically contraindicated.	
			b. Each resident is given an opportunity to participate in planning his total care and medical treatment.	
			c. Each resident is given an opportunity to refuse treatment.	
			d. Each resident gives informed, written consent before participating in experimental research.	
			e. If the physician decides that informing the resident of his health and medical condition is medically contraindicated, the physician has documented this decision in the resident's medical record.	
			3. Transfer and Discharge	
			Each resident is transferred or discharged only for: a. Medical reasons. b. His/her welfare or that of other residents. c. Nonpayment except as prohibited by the Medicare or Medicaid program.	
			4. Exercising Rights	
			a. Each resident is encouraged and assisted to exercise his/her rights as a resident of the facility and as a citizen.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			b. Each resident is allowed to submit complaints and recommendations concerning the policies and services of the facility to staff or to outside representatives of the resident's choice or both.	
			c. Such complaints are submitted free from restraint, coercion, discrimination, or reprisal.	
			5. Financial Affairs	
			a. Residents are allowed to manage their own personal financial affairs.	
			b. The facility establishes and maintains a system that assures full and complete accounting of residents' personal funds. An accounting report is made to each resident at least on a quarterly basis.	
			c. The facility does not commingle resident funds with any other funds other than patient funds.	
			d. If a resident requests assistance from the facility in managing his personal financial affairs, resident's delegation is in writing.	
			e. The facility system of accounting includes written receipts for: All personnal possessions and funds received by or deposited with the facility. All disbursements made to or for the resident.	
			f. The financial record must be available to the resident and his/her family.	
			6. Freedom from Abuse and Restraints	
			a. Each resident is free from mental and physical abuse.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			b. Chemical and physical restraints are only used when authorized by a physician in writing for a specified period of time or in emergencies.	
			c. If used in emergencies, they are necessary to protect the resident from injury to himself or others.	
			d. The use is authorized by a professional staff member identified in the written policies and procedures of the facility.	
			e. The use is reported promptly to the resident's physician by the staff member.	
			7. Privacy	
			a. Each resident is treated with respect, consideration and full recognition of his/her dignity and individuality.	
			b. Each resident is given privacy during treatment and care of personal needs.	
			c. Each resident's records, including information in an automatic data bank, are treated confidentially.	
			d. Each resident must give written consent before the facility releases information from his/her record to someone not otherwise authorized to receive it.	
			e. Married residents are given privacy during visits by their spouses.	
			f. Married residents are permitted to share a room.	
			8. Work	
			No resident may be required to perform services for the facility.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			9. Freedom of Association and Correspondence a. Each resident is allowed to communicate, associate and meet privately with individuals of his choice unless this infringes upon the rights of another resident. b. Each resident is allowed to send and receive personal mail unopened.	
			10. Activities Each resident is allowed to participate in social, religious, and community group activities.	
			11. Personal Possessions Each resident is allowed to retain and use his personal possessions and clothing as space permits.	
			12. Written Policies and Procedures: Delegation of Rights and Responsibilities ICF (442.312) ☐ MET ☐ NOT MET a. The facility has written policies and procedures that provide that all the rights and responsibilities of a resident pass to the resident's guardian, next of kin or sponsoring agency or agencies if the resident is adjudicated incompetent under State law or is determined by his physician to be incapable of understanding his rights and responsibilities. b. Physician determinations of incapability and the specific reasons thereof are recorded by the physician in the resident's record.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			K. Resident Care Policies	
			SNF (405.1121(1)) ☐ MET ☐ NOT MET	
			1. The facility has written policies to govern the continuing skilled nursing care and related medical or other services provided.	
			2. These policies reflect awareness of and provision for meeting the total medical and psychosocial needs of residents including admission, transfer, discharge planning, and the range of services available to residents; and	
			3. The protection of residents' personal and property rights.	
			4. The policies are developed by a group of professional personnel, including the Medical Director or the organized medical staff, and are periodically reviewed and revised (if necessary).	
			5. These policies are available to admitting physicians, sponsoring agencies, residents, and the public.	
			6. The Medical Director or a registered nurse is designated as responsible for the execution of the policies.	
			L. Public Availability	
			ICF (442.305) ☐ MET ☐ NOT MET	
			1. The facility has written policies and procedures governing all the services it provides.	
			2. The policies and procedures are available to the staff and residents, members of the family, the public, and legal representatives of residents.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			M. Admissions ICF (442.306) ☐ MET ☐ NOT MET The facility has written policies and procedures that insure that it admits as residents only those residents who needs can by met by: 1. the facility itself. 2. the facility in coperation with community resources. 3. the facility in cooperation with other providers of care affiliated with or under contract to the facility.	
			N. Transfers ICF (442.307) ☐ MET ☐ NOT MET 1. The facility has written policies and procedures to ensure that residents are transferred promptly to a hospital, SNF or other appropriate facility when a change is necessary. 2. Except in emergencies, the facility consults the resident, his next of kin, the attending physician, and the responsible agency, if any, at least five days before discharge. 3. The facility uses casework services and other means to insure that adequate arrangements are made to meet resident's needs through other resources.	

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

O. Restraints

ICF (442.308) ☐ MET ☐ NOT MET

The facility has written policies and procedures that:

1. Define the uses of chemical and physical restraints.
2. Identify the professional personnel who may authorize the use of restraints in emergencies under 442.320(f).
3. Describe procedures for monitoring and controlling the use of these restraints.

P. Complaints

ICF (442.309) ☐ MET ☐ NOT MET

The facility has written policies and procedures that:

1. Describe the procedures the facility uses to receive complaints and recommendations from residents.
2. Insure that the facility responds to complaints and recommendations.

Q. Staff Development

SNF (405.1121(h)) ☐ MET ☐ NOT MET

ICF (442.314) ☐ MET ☐ NOT MET

1. The facility conducts an orientation program for all new employees that includes a review of all its policies.
2. The facility plans and conducts an inservice staff development program for all personnel to assist them in developing and improvifng their skills.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			3. The facility maintains a record of the orientation and staff development programs it conducts.	
			4. The record includes the content of the program and the names of participants.	
			5. Inservice training includes at least prevention and control of infections, fire prevention and safety, confidentiality of resident information, and preservation of resident dignity including protction of resident's privacy and personal and property rights.	
			MEDICAL DIRECTION (Condition of Participation) SNF (405.1122) ☐ MET ☐ NOT MET The facility has a written agreement with a licensed physician to serve as Medical Director on a part-time or full-time basis as is appropriate to the needs of the residents and the facility. (See 405.1911(b)) regarding waiver of this requirement.)	
			A. Coordination of Medical Care SNF (405.1122(a)) ☐ MET ☐ NOT MET	
			1. Medical direction and coordination of medical care in the facility are provided by a Medical Director.	
			2. The Medical Director is responsible for development of policies approved by the governing body.	
			3. Coordination of medical care includes liaison with attending physicians to ensure their writing orders promptly upon admission of a resident, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

B. Responsibilities to the Facility

SNF (405.1122(b)) ☐ MET ☐ NOT MET

1. The Medical Director is responsible for surveillance of the health status of the facility's employees.
2. Incidents and accidents that occur on the premises are reviewed by the Medical Director to identify hazards to health and safety.

PHYSICIAN SERVICES (Condition of Participation)

SNF (405.1123) ☐ MET ☐ NOT MET

Residents in need of skilled or rehabilitative care are admitted to the facility only upon the recommendation of, and remain under the care of, a physician. To the extent feasible, each resident designates a personal physician.

A. Physician Supervision

SNF (405.1123(b)) ☐ MET ☐ NOT MET

ICF (442.346) ☐ MET ☐ NOT MET

1. The facility has a policy that the health care of every resident must be under the supervision of a physician.
2. All attending physicians must make arrangements for the medical care of their residents in their absence.

B. Emergency Services

SNF (405.1123(c)) ☐ MET ☐ NOT MET

The facility has written procedures available at each nurses' station, that provide for having a physician available to furnish necessary medical care in case of emergency.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

NURSING SERVICES (Condition of Participation)

SNF (405.1124) ☐ MET ☐ NOT MET

The facility provides 24-hour service by licensed nurses, including the services of a registered nurse at least during the day tour of duty, 7 days a week. There is an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing needs of all residents. (See 405.1911(a)) regarding waiver of the 7-day registered nurse requirement.)

ICF (442.342) ☐ MET ☐ NOT MET

The facility provides nursing care as needed including restorative nursing care.

A. Director of Nursing Services

SNF (405.1124 (a)) ☐ MET ☐ NOT MET

1. The director of nursing services is a qualified registered nurse employed full time.
2. The director of nursing services has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff, and serves only one facility in this capacity.
3. If the director of nursing services has other institutional responsibilities, a qualified registered nurse serves as assistant so that there is the equivalent of a full-time director of nursing services on duty.

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

B. Health Services Supervision

ICF (442.339) ☐ MET ☐ NOT MET

1. The facility has a full-time registered nurse, or a licensed practical or vocational nurse to supervise the health services 7 days a week on the day shift.

2. The nurse has a current State license.

3. If the supervisor of health services is a licensed practical or vocational nurse, the facility has a formal contract with a registered nurse to serve as a consultant no less than 4 hours a week.

4. To qualify to serve as a health services supervisor, a licensed practical or vocational nurse must:

   a. have graduated from a State-approved school of practical nursing, or

   b. Have education or other training that the State authority responsible for licensing practical nurses considered equal to graduation from a State-approved school of practical nursing, or

   c. Have passed the Public Health Service examination for waivered licensed practical or vocational nurses.

5. If the nurse in charge is licensed by the State in category other than registered nurse or licensed practical or vocational nurse:

   a. The individual has completed a training program to get the license that includes at least the same number of classroom and practice hours in all nursing subjects as in the program of a State-approved school of practical or vocational nursing, and

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

b. The State agency responsible for licensing the individual submits a report to the Medicaid agency comparing State-licensed practical nurse or vocational nurse course requirements with those for the program completed by the individual.

C. Twenty-four Hour Nursing Service

SNF (405.1124(c) ☐ MET ☐ NOT MET

ICF (442.338) ☐ MET ☐ NOT MET

1. 24-Hour Nursing

Nursing policies and procedures address the total nursing needs of the residents.

The policies are designed to ensure that each patient receives:

Treatment.

Medications as prescribed.

Diet as prescribed.

Rehabilitative nursing care as needed.

Proper care to prevent decubitus ulcers and deformities.

Proper care to ensure that residents are clean, well-groomed and comfortable.

Protection from accident and injury.

Protection from infection.

Encouragement, assistance, and training in self-care and group activities.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			2. Weekly time schedules are maintained and indicate the number and classifications of nursing personnel including relief personnel, who worked on each unit for each tour of duty.	
			D. Rehabilitative Nursing Care SNF (405.1124(e)) ☐ MET ☐ NOT MET Nursing personnel are trained in rehabilitative nursing.	
			E. Supervision of Resident Nutrition SNF (405.1124(f)) ☐ MET ☐ NOT MET A procedure is established to inform dietetic service of physicians' diet orders and of residents' dietetic problems. F. Administration of Drugs SNF (405.1124(g)) ☐ MET ☐ NOT MET Procedures are established by the Pharmaceutical Services Committee (see 405.1127(d)) to ensure that drugs are checked against physicians' orders.	
			G. Conformance with Physicians' Drug Orders SNF (405.1124(h)) ☐ MET ☐ NOT MET Indicators 1 thru 4 apply to SNFs. ICF (442.335) ☐ MET ☐ NOT MET 1. Drugs not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies.	

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

2. The attending physician is notified of an automatic stop order prior to the last dose so that the physician may decide if the administration of the drug or biological is to be continued or altered.

ICF (442.334) ☐ MET ☐ NOT MET

3. Physicians' verbal orders for drugs are given only to a licensed nurse, pharmacist, or physician and are immediately recorded and signed by the person receiving the order. (Verbal orders for Schedule 11 drugs are permitted only in the case of a bona fide emergency situation.)

4. Such orders are countersigned by the attending physician within a reasonable time.

H. Storage of Drugs and Biologicals

SNF (405.1124(i)) ☐ MET ☐ NOT MET

1. Procedures for storing and disposing of drugs and biologicals are estabished by the pharmaceutical services committee.

2. In accordance with State and Federal laws, all drugs and biologicals, are stored in locked compartments under proper temperature controls.

3. Only authorized personnel have access to the keys.

4. Separately locked, permanently affixed compartments are provided for storage of controlled drugs listed in Schedule 11 of the Comprehensive Drug Abuse Prevention & Control Act of 1970 and other drugs subject to abuse, except under single unit dosage distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			5. An emergency medication kit approved by the pharmaceutical services committee is kept readily available.	
			DIETETIC SERVICES (Condition of Participation) SNF (405.1125) ☐ MET ☐ NOT MET The facility provides a hygienic dietetic service that meets the daily nutritional needs of patients, ensures that special dietary needs are met, and provides palatable and attractive meals. A facility that has a contract with an outside food management company may be found to be in compliance with this condition provided the facility and/or company meets the standards listed herein.	
			A. Staffing SNF (405.1125(a)) ☐ MET ☐ NOT MET 1. Overall supervisory responsibility for the dietetic service is assigned to a full-time qualified dietetic service supervisor. 2. If the dietetic service supervisor is not a qualified dietitian, the dietetic service supervisor functions with frequent, regularly scheduled consultation from a person so qualified. (§405.1101(f).) 3. In addition, the facility employs sufficient supportive personnel competent to carry out the functions of the dietetic service.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			4. If consultant dietetic services are used, the consultant's visits are at appropriate times, and of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the dietetic service, approval of all menus, and participation in the development or revisions of dietetic policies and procedures. (See §405.1121(g).)	
			B. ICF (442.332) ☐ MET ☐ NOT MET 1. The facility has a staff member trained or experienced in food management or nutrition who is responsible for: a. Planning meals that meet the nutrititional needs of each resident. b. Following the orders of the resident's physician. c. To the extent medically possible, following the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences (Recommended Dietary Allowances, 8th Ed., 1974). d. Supervising the meal preparation and service to insure that the menu plan is followed. 2. For residents who required medically prescribed special diets, the facility: a. has menus for those residents planned by a professionally qualified dietitian or reviewed and approved by the attending physician; and	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

b. Supervises the preparation and serving of meals to insure that the resident accepts the special diet.

3. The facility keeps for 30 days a record of each menu as served.

C. Hygiene of Staff

SNF (405.1125(f)) ☐ MET ☐ NOT MET

In the event food service employees are assigned duties outside the dietetic service, these duties do not interfere with the sanitation, safety, or the time required for dietetic work assignments. (See §405.1121(f).)

D. Sanitary Conditions

SNF (405.1125(g)) ☐ MET ☐ NOT MET

Written reports of inspections by State and local health authorities are on file at the facility, with notation made of action taken by the facility to comply with any recommendations.

SPECIALIZED REHABILITATION SERVICES
(Condition of Participation)

SNF (405.1126) ☐ MET ☐ NOT MET

The facility provides, or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (i.e., physical therapy, speech pathology and audiology, and occupational therapy) as needed by residents to improve and maintain functioning.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			Safe and adequate space and equipment are available, commensurate with the services offered. If the facility does not offer such services directly, it does not admit nor retain residents in need of this care unless provision is made for such services under arrangement with qualified outside resources under which the facility assumes professional responsibility for the services rendered. (See §405.1121(h).)	

A. Staffing and Organization

SNF (405.1126(a)) ☐ MET ☐ NOT MET

Indicators 1 thru 3 apply to SNFs

ICF (442.343(d)(1)(2)) ☐ MET ☐ NOT MET

1. Specialized rehabilitative services are provided, in accordance with accepted professional practices, by qualified therapists or by qualified assistants or other supportive personnel under the supervision of qualified therapists.

2. Other rehabilitative services also may be provided, but must be in a faciity where all rehabilitative services are provided through an organized rehabilitative service under the supervision of a physician qualified in physical medicine who determines the goals and limitations of these services and assigns duties appropriate to the training and experience of those providing such services.

Exception: Does not apply to ICFs.

3. Written administrative and resident care policies and procedures are developed for rehabilitative services by appropriate therapists and representatives of the medical, administrative, and nursing staffs.

Exception: Does not apply to ICF's
See General Requirements 442.305

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			B. Documentation of Services SNF (405.1126(c)) ☐ MET ☐ NOT MET The physician's order, the plan of rehabilitative care, services rendered, evaluations of progress, and other pertinent information are recorded in the patient's medical record, and are dated and signed by the physician ordering the service and the person who provided the service.	
			C. Qualifying to Provide Outpatient Physical Therapy Services SNF (405.1126(d)) ☐ MET ☐ NOT MET If the facility provides outpatient physical therapy services, it meets the applicable health and safety regulations pertaining to such services as are included in Subpart Q of this part. (See §405.1717, 405.1718, 405,1719, 405.1723, and 405.1726.)	
			PHARMACEUTICAL SERVICES (Condition of Participation) SNF (405.1127) ☐ MET ☐ NOT MET The facility has appropriate methods and procedures for the dispensing and administeridng of drugs and biologicals. The facility is responsible for providing such drugs and biologicals for its residents, insofar as they are covered under the programs, and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			A. Supervision of Services	

A. Supervision of Services

SNF (405.1127(a)) ☐ MET ☐ NOT MET

1. The pharmaceutical services are under the general supervision of a qualified pharmacist.

2. The pharmacist is responsible to the administrative staff for developing coordinating, and supervising all pharmaceutical services.

3. The pharmacist (if not a full-time employee) devotes a sufficient number of hours, based upon the needs of the facility, during regularly scheduled visits to carry out these responsibilities.

ICF (442.333) ☐ MET ☐ NOT MET

1. The facility employs a licensed pharmacist, or

2. The facility has formal arrangements with a licensed pharmacist to advise the facility on ordering, storage, administration, disposal and recordkeeping of drugs and biologicals.

B. Control and Accountability

SNF (405.1127(b)) ☐ MET ☐ NOT MET

1. The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility.

2. Only approved drugs and biologicals are used in the facility.

3. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			C. Pharmaceutical Services Committee SNF (405.1127(d)) ☐ MET ☐ NOT MET 1. A pharmaceutical services committee or its equivalent develops written policies and procedures for safe and effective drug therapy, distribution, control and use. 2. The committee is comprised of at least the pharmacist, the director of nursing services, the administrator, and one physician. 3. The committee oversees pharmaceutical services in the facility, makes recommendations for improvement,and monitors the service to ensure its accuracy and adequacy.	
			LABORATORY AND RADIOLOGIC SERVICES (Condition of Participation) SNF (405.1128) ☐ MET ☐ NOT MET The facility has provision for promptly obtaining required laboratory, X-ray, and other diagnostic services.	
			A. Provision of Services SNF (405.1128(a)) ☐ MET ☐ NOT MET 1. If the facility provides its own laboratory and X-ray services, these meet the applicable conditions established for certification of hospitals that are contained in 405.1028 and 405.1029, respectively.	

NAME OF FACILITY

YES | NO | N/A

2. If the facility itself does not provide such services, arrangements are made for obtaining these services from a physician's office, a participating hospital or skilled nursing facility, or a portable X-ray supplier or independent laboratory which is approved to provide these services under the program.

3. The facility assists the resident, if necessary, in arranging for transportation to and from the source of service.

B. Blood and Blood Products

SNF (405.1128(b)) ☐ MET ☐ NOT MET

1. Blood handling and storage facilities are safe, adequate, and properly supervised.

2. If the facility provides for maintaining and transfusing blood and blood products, it meets the conditions established for certification of hospitals that are contained in §405.1028(j).

3. If the facility does not provide its own facilities but does provide transfusion services alone, it meets at least the requirements of §405.1028(j)(1),(3),(4),(6), and (9).

DENTAL SERVICES (Condition of Participation)

SNF (405.1129) ☐ MET ☐ NOT MET

The facility has satisfactory arrangements to assist residents to obtain routine and emergency dental care (See §405.1121(h). (The basic Hospital Insurance Program does not cover the services of a dentist in a skilled nursing facility in connection with the care, treatment, filling, removal, or replacement of teeth or structures supporting the teeth; and only certain oral surgery is included in the Supplemental Medical Insurance Program.)

EXPLANATORY STATEMENTS

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

A. Advisory Dentist

SNF (405.1 29(a)) ☐ MET ☐ NOT MET

A dentist recommends oral hygiene policies and practices for the care of residents. (§405.1121(g).

B. Arrangements for Outside Services

SNF (405.1129(b)) ☐ MET ☐ NOT MET

1. The facility has a cooperative agreement with a dentist, or
2. Maintains a list of dentists in the community for residents who do not have a private dentist.
3. The facility assists the resident, if necessary, in arranging for transportation to and from the dentist's office.

SOCIAL SERVICES (Condition of Participation)

SNF (405.1130) ☐ MET ☐ NOT MET

The facility has satisfactory arrangements for identifying the medically related social and emotional needs of the resident. It is not mandatory that the skilled nursing facility itself provide social services in order to participate in the program. If the facility does not provide social services, it has written procedures for referring residents in need of social services to appropriate social agencies. If social services are offered by the facility, they are provided under a clearly defined plan, by qualified persons, to assist each resident to adjust to the social and emotional aspects of the resident's illness, treatment, and stay in the facility.

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

A. Social Service Functions

SNF (405.1130(a)) ☐ MET ☐ NOT MET

Services are provided to meet the social and emotional needs of residents by qualified staff of the facility, or by referral, based on established procedures, to appropriate social agencies.

ICF (442.344(b)) ☐ MET ☐ NOT MET

The facility either provides these services itself or arranges for them with qualified outside resources.

B. Staffing

SNF (405.1130 (b)) ☐ MET ☐ NOT MET

1. If the facility offers social services, a member of the staff of the facility is designated as responsible for social services.
2. If the designated person is not a qualified social worker, the facility has a written agreement with a qualified social worker or recognized social agency for consultation and assistance on a regularly scheduled basis. (See §405.1101(s).)
3. The social service also has sufficient supportive personnel to meet resident needs.
4. Facilities are adequate for social service personnel, easily accessible to residents and medical and other staff, and ensure privacy for interviews.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			ICF (442.344(c)) ☐ MET ☐ NOT MET The facility designates one staff member, qualified by training or experience, to be responsible for: a. Arranging for social services; and b. Integrating social services with other elements of the plan of care.	
			C. Records and Confidentiality SNF (405.1130(c)) ☐ MET ☐ NOT MET Records of pertinent social data about personal and family problems medically related to the resident's illness and care, and of action taken to meet the resident's needs, are maintained in the resident's medical record. If social services are provided by an outside resource, a record is maintained of each referral to such resource.	
			ACTIVITIES (Condition of Participation) SNF (405.1131) ☐ MET ☐ NOT MET The facility provides for an activities program, appropriate to the needs and interests of each resident, to encourage self care, resumption of normal activities, and maintenance of an optimal level of psychosocial functioning.	

NAME OF FACILITY

YES | NO | N/A

EXPLANATORY STATEMENTS

A. Staffing

SNF (405.1131(a) ☐ MET ☐ NOT MET

A member of the facility's staff is designated as responsible for the activities program.

If not a qualified activities coordinator, this staff member functions with frequent, regularly scheduled consultation from a person so qualified. (See §405.1101(o).)

ICF (442.345(b)) ☐ MET ☐ NOT MET

The facility designates one staff member, qualified by training or experience in directing group activity, to be responsible for activity services.

MEDICAL RECORDS (Condition of Participation)

SNF (405.1132) ☐ MET ☐ NOT MET

The facility maintains clinical (medical) records on all residents in accordance with accepted professional standards and practices. The medical record service has sufficient staff, facilities, and equipment to provide medical records that are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

ICF (442.318(a)) ☐ MET ☐ NOT MET

The facility maintains an organized resident record system that contains a record for each resident.

NAME OF FACILITY

YES | NO | N/A

A. Staffing

SNF (405.1132(a)) ☐ MET ☐ NOT MET

1. Overall supervisory responsibility for the medical record service is assigned to a full-time employee of the facility.

2. The facility also employs sufficient supportive personnel competent to carry out the functions of the medical record service.

3. If the medical record supervisor is not a qualified medical record practitioner, this person functions with consultation from a person so qualified. (See §405.1101(1).)

B. Protection of Medical Record Information

SNF (405.1132(b)) ☐ MET ☐ NOT MET

ICF (442.318(d)) ☐ MET ☐ NOT MET

The facility safeguards medical record information against loss, destruction, or unauthorized use.

C. Physician Documentation

SNF 405.1132(d) ☐ MET ☐ NOT MET

1. Only physicians enter or authenticate in medical records opinions that require medical judgment (in accordance with medical staff bylaws, rules, and regulations, if applicable).

2. All physicians sign their entries into the medical record.

EXPLANATORY STATEMENTS

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			D. Completion of Records and Centralization of Reports SNF 405.1132(e) ☐ MET ☐ NOT MET 1. Current medical records and those of discharged residents are completed promptly. 2. All clinical information pertaining to a resident's stay is centralized in the resident's medical record.	
			E. Retention and Preservation SNF (405.1132(f)) ☐ MET ☐ NOT MET Medical records are retained for a period of time not less than that determined by the respective State statute, the statue of limitations in the State, or 5 years from the data of discharge in the absence of a State statute, or, in the case of a minor, 3 years after the patient becomes of age under State law. ICF (442.318(e)) ☐ MET ☐ NOT MET The facility must keep a resident's record for at least 3 years after the resident is discharged.	
			F. Location and Facilities SNF (405.1132(h)) ☐ MET ☐ NOT MET The facility maintains adequate facilities and equipment, conveniently located to provide efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			TRANSFER AGREEMENT (Condition of Participation) SNF (405.1133) ☐ MET ☐ NOT MET ICF (442.316) ☐ MET ☐ NOT MET The facility has in effect a transfer agreement with one or more hospitals approved for participation under the programs, which provides the basis for effective working arrangements under which inpatient hospital care or other hospital services are available promptly to the facility's residents when needed. (A facility that has been unable to establish a transfer agreement with the hospital(s) in the community or service area after documented attempts to do so is considered to have such an agreement in effect.) Exception: A facility that has been unable to establish a written agreement after documented attempts to do so, is considered to have such an agreement.	
			A. Resident Transfer SNF (405.1133(a)) ☐ MET ☐ NOT MET A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case of two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that: 1. Transfer of patients will be effected between the hospital and the skilled nursing facility, ensuring timely admission, whenever such transfer is medically appropraite as determined by the attending physician.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			2. There will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions. 3. Security and accountability for patients' personal effects are provided on transfer.	
			PHYSICAL ENVIRONMENT (Condition of Participation) SNF (405.1134) ☐ MET ☐ NOT MET The facility is constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.	
			A. Life Safety from Fire SNF (405.1134(a)) ☐ MET ☐ NOT MET ICF (442.321) ☐ MET ☐ NOT MET (See appropriate HCFA Fire Safety survey form.)	
			B. Maintenance of Equipment, Building, and Grounds SNF (405.1134(i)) ☐ MET ☐ NOT MET The facility establishes a written preventitive maintenance program to ensure that all equipment is operative.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			INFECTION CONTROL (Condition of Participation) SNF (405.1135) ☐ MET ☐ NOT MET The facility establishes an infection control committee of representative professional staff with responsibility for overall infection control in the facility. All necessary housekeeping and maintenance services are provided to maintain a sanitary and comfortable environment and to help prevent the development and transmission of infection.	
			A. Infection Control Committee SNF (405.1135(a)) ☐ MET ☐ NOT MET 1. The infection control committee is composed of members of the medical and nursing staffs, administration, and the dietetic, pharmacy, housekeeping, maintenance, and other services. 2. The committee establishes policies and procedures for investigating, controlling, and preventing infection in the facility. 3. The committee monitors staff performance to ensure that the policies and procedures are executed.	
			B. Aseptic and Isolation Techniques SNF (405.1135(b)) ☐ MET ☐ NOT MET 1. The facility has written procedures for aseptic and isolation techniques. 2. These procedures are reviewed and revised for effectiveness and improvement as necessary.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			C. Housekeeping SNF (405.1135(c)) ☐ MET ☐ NOT MET 1. The facility employs sufficient housekeeping personnel. 2. Provides all necessary equipment to maintain a safe, clean and orderly interior. 3. A full-time employee is designated responsible for the services and for supervison and training of personnel. 4. If a facility has a contract with an outside resource for housekeeping services, the facility and/or outside resource meets the requirements of the standards.	
			D. Pest Control SNF (405.1135(e)) ☐ MET ☐ NOT MET The facility has an ongoing pest control program.	
			DISASTER PREPAREDNESS (Condition of Participation) SNF (405.1136) ☐ MET ☐ NOT MET The facility has a written plan, periodically rehearsed, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (residents and personnel) arising from such disasters.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

A. Plan

ICF (442.313(a)(b)) ☐ MET ☐ NOT MET

1. The facility has a written plan for staff and residents to follow in case of emergencies such as fire or explosion.

2. The facility rehearses the plan regularly.

3. The facility has written procedures for the staff to follow in case of an emergency involving an individual resident.

4. These procedures include:

   a. Caring for the resident.

   b. Notifying the attending physician and other individuals responsible for the resident.

   c. Arranging for transportation, hospitalization, and other appropriate services.

SNF (405.1136(a)) ☐ MET ☐ NOT MET

1. The facility has an acceptable written plan in operation, with procedures to be followed in the event of fire, explosion, or other disaster.

2. The plan is developed and maintained with the assistance of qualified fire, safety, and other appropriate experts.

3. Includes procedures for prompt transfer of casualties and records.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

4. Instructions regarding the location and use of alarm systems and signals and of fire-fighting equipment.

5. Information regarding methods of containing fire.

6. Procedures for notification of appropriate persons.

7. Specifications of evacuation routes and procedures. (See §405.1134(a).)

B. Orientation and Training

SNF (405.1136(b)) ☐ MET ☐ NOT MET

The disaster program includes orientation and ongoing training and drills for all personnel in all procedures so that each employee promptly and correctly carries out a specific role in case of a disaster. (See §405.1121(g).)

UTILIZATION REVIEW (Condition of Participation)

SNF (405.1137) ☐ MET ☐ NOT MET

The facility carries out utilization review of the services provided in the facility to residents who are entitled to benefits under the program(s). Utilization review assures the maintenance of high quality care and appropriate and efficient utilization of facility services. There are two elements to utilization review: medical care evaluation studies and review of extended duration cases.

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS

A. Plan

SNF (405.1137(a)) ☐ MET ☐ NOT MET

1. The facility has a currently applicable written description of its utilization review plan.

2. Such description includes:

   a. The organization and composition of the committee or group which will be responsible for the utilization review function.

   b. Methods of criteria (including norms where available) to be used to define periods of continuous extended duration and to assign or select subsequent dates for continued stay review.

   c. Methods for selection and conduct of medical care evaluation studies.

b. Organization and Composition of Utilization Review Committees

SNF (405.1137(b)) ☐ MET ☐ NOT MET

1. The utilization review (UR) function is conducted by:

   a. A staff committee of the skilled nursing facility which is composed of two or more physicians, with participation of other professional personnel; or,

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			b. A group outside the facility which is similarly composed and which is established by the local medical or osteopathic society and some or all of the hospitals and skilled nursing facilities in the locality; or (indicate name of the outside group and briefly describe the organization.) c. A group established and organized in a manner approved by the Secretary that is capable of performing such function. 2. The medical care evaluation studies, educational duties of the review program, and the review of admissions and long-stay cases are performed by: a. the same committee or group; b. or more committees or groups. Briefly explain who performs these functions.	
			C. Medical Care Evaluation Studies SNF (405.1137(c)) ☐ MET ☐ NOT MET 1. Medical care evaluation studies are performed to promote the most effective and efficient use of available health facilities and services consistent with resident needs and professionally recognized standards of health care. 2. Studies emphasize identification and analysis of patterns of resident care and suggest, where appropriate, possible changes for maintaining consistently high quality care and effective and efficient use of services.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			3. Each medical care evaluation study identifies and analyzes factors related to the care rendered in the facility and where indicated, results in recommendations for change beneficial to residents, staff, the facility, and the community. 4. Studies, on a sample or other basis, include, but need not be limited to, admissions, durations of stay, ancillary services furnished (including drugs and biologicals), and professional services performed on premises. At least one study was completed during the last year. Type of study last completed: ____________________	
			D. Extended Stay Review SNF (405.1137(d)) ☐ MET ☐ NOT MET 1. Periodic review is made of each current inpatient skilled nursing facility beneficiary case of continuous extended duration, and the length of which is defined in the utilization review plan to determine whether further inpatient stay is necessary. 2. The review is based on the attending physician's reasons for and plan for continued stay and any other documentation the committee or group deems appropriate. 3. Cases are screened by: a. A qualified non-physician representative of the committee. b. The group.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			c. The reviewer uses criteria established by the physician members of the committee.	
			4. In instances when non-physician members are utilized, those cases are referred to a physician member for further review when it appears that the resident no longer requires further inpatient care.	
			5. Non-physician representatives used to screen extended stay review cases, have experience in such screening or appropriate training in the application of the screening criteria used, or both.	
			6. Before the expiration of each new period, the case must be reviewed again in like manner with such reviews being repeated as long as the stay continues beyond the scheduled review dates and notice has not been given pursuant to paragraph (e) of this section.	
			E. Further Stay Not Medically Necessary SNF (405.1137(e)) ☐ MET ☐ NOT MET	
			1. A final determination of the committee or group that continued stay is not medically necessary is made by at least two physician members of the committee or group, except that the final determination may be made by one physician where the attending physician, when given an opportunity to express his views, does not do so, or does not contest the finding that the continued stay is not medically necessary.	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
			2. If the commitee or group, or its non-physician representative where a physician member concurs, has reason to believe from the review of an extended duration case or a case reviewed a part of a medical care evaluation study that further stay is no longer medically necessary, the committee or group shall notify the individual's attending physician and afford him an opportunity to present his views before it makes a final determination.	
			3. If the final determination of the committee or group is that further stay is no longer medically necessary, written notification of the finding is given to the facility, the attending physician, and the individual (or where appropriate, his next of kin) no later than 2 days after such final determination is made and, in no event in the case of an extended duration case, later than 3 working days after the end of the extended duration period specified pursuant to paragraph (d) of this section.	
			F. Administrative Responsibilities SNF (405.1137(f)) ☐ MET ☐ NOT MET The administrative staff of the facility is kept directly and fully informed of committee activities to facilitate support and assistance. (Explain)	
			G. Utilization Review Records SNF (405.1137(g)) ☐ MET ☐ NOT MET 1. Written records of committee activities are maintained.	

NAME OF FACILITY

YES | NO | N/A | EXPLANATORY STATEMENTS

2. Appropriate reports, signed by the committee chairman, are made regularly to the medical staff, administrative staff, governing body, and sponsors (if any).

3. Minutes of each committee meeting is maintained and include at least:

   a. Name of committee.

   b. Date and duration of meeting.

   c. Names of committee members present and absent.

4. Description of activities presently in progress to satisfy the requirements for medical care evaluation studies, including the subject, reason for study, dates of commencement and expected completion, summary of studies completed since the last meeting, conclusions and follow-up on implementation of recommendations made from previous studies.

5. Summary of extended duration cases reviewed including the number of cases, identification number, admission and review dates, and decisions reached, including the basis for each determination and action taken for each case not approved for extended care.

H. Discharge Planning

SNF (405.1137(h)) ☐ MET ☐ NOT MET

The facility maintains a centralized, coordinated program to ensure that each resident has a planned program of continuing care which meets his postdischarge needs.

YES	NO	N/A		EXPLANATORY STATEMENTS
			1. The facility has in operation an organized discharge planning program. The utilization review committee, in its evaluation of the current status of each extended duration case, has available to it the results of such discharge planning and information on alternative available community resources to which the resident may be referred.	
			2. The facility maintains written discharge planning procedures which describe: a. How the discharge coordinator will function, and his authority and relationships with the facility's staff. b. The maximum time period after which reevaluation of each resident's discharge plan is made. c. Local resources available to the facility, the resident, and the attending physician to assist in developing and implementing individual discharge plans; and d. Provisions for periodic review and reevaluation of the facility's discharge planning program.	
			3. At the time of discharge, the facility provides those responsible for the resident's post discharge care with appropriate summary of information about the discharged resident to ensure the optimal continuity of care. The discharge summary includes at least the following:	

NAME OF FACILITY

YES	NO	N/A		EXPLANATORY STATEMENTS
4c			a. Current information relative to diagnoses. b. Rehabilitation potential. c. A summary of the course of prior treatment. d. Physician orders for the immediate care of the resident. e. Pertinent social information.	

COMPLIANCE STATEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ANDMINISTRATION

INSTRUCTIONS FOR THE COMPLETION OF LONG-TERM CARE FACILITY REQUEST FOR CERTIFICATION IN THE MEDICARE AND/OR MEDICAID PROGRAM

Submission of this form will initiate the process of obtaining a decision as to whether the conditions of participation are met. Do not delay returning the form even though certain information is not now available. Assistance in completing the form is available from the State agency.

Answer all questions as of the current date. Return the original and first two copies to the State agency in the envelope provided; retain the last copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Office.

Detailed instructions or definitions are given below for questions other than those considered self-explanatory.

Medicare/Medicaid Provider Number--Leave blank on all initial certifications. On all recertifications, insert the facility's assigned six-digit provider number.

State/County and State Region Codes--Leave Blank. The Health Care Financing Administration Regional Office will complete.

State Vendor Number--Complete only in those states which assign separate State vendor numbers (or Medicaid I.D. numbers) for internal controls. If a State does not have such a system, leave blank.

Question II--"SNF/ICF"--If the facility is dually certified for SNF and ICF care or is a SNF with a distinct part ICF, check "03" (SNF/ICF).

Question IV--If a service is provided directly by the facility, mark a "1" in the block. If a service is provided under arrangement with an outside resource, mark a "2" in the block. If a service is provided by a combination of both, mark a "3" in the block.

Question V--For the blocks marked "1" in question IV, enter the Fulltime Staff Equivalents. The first 2 categories are for nursing personnel; the third category is for other bed care personnel. The last category (All other Personnel) should include personnel for all the other services in Question IV for which you entered a "1". To determine fulltime equivalents, add the total number of hours worked by all employees in each classification in the week prior to the week of filing the request and divide by the number of hours in the standard work week. If the result is not a whole number express it to the nearest quarter decimal (e.g., .00, .25, .50, .75)

"Substantive Changes in Facility Management and Operation" - is defined as changes in the operation and management of the facility which affect major revisions to the accompanying administrative and procedural requirements (Examples: new administrator, new long term care classification; new admissions criteria (categories of patients accepted)). Change in ownership, however, will remain reportable using the HCFA-1513, "Ownership and Control Interest Disclosure Statement."

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATRION

LONG-TERM CARE FACILITY
REQUEST FOR CERTIFICATION
IN THE MEDICARE AND/OR MEDICAID PROGRAM

(Please Read Instructions Before Completing This Form)

Medicare/Medicaid Provider No. (N1)		State Vendor Number
State County Code (N3)	State Region Code (N4)	Fiscal Year Ending Date
I. IDENTIFYING INFORMATION	Name of Facility City, County, and State	Street Address Zip Code Telephone Number (N7)

II. TYPE OF FACILITY (See Instructions)	A. 01 Skilled Nursing Facility (SNF) 02 Intermediate Care Facility (ICF) 03 SNF/ICF 04 Intermediate Care Facility For the Mentally Retarded (N14) ☐	
	B. Is this facility hospital based? (N5) 01 Yes 02 No ☐ If yes, indicate hospital provider Number (N8) ______________	
	C. If "01" or "03" in A. is completed, indicate the type of program participation requested: 01 Medicare 02 Medicaid 03 Both (N13) ☐	
III. TYPE OF CONTROL	Voluntary Non-Profit 01 Church 02 Private 03 Other Specify ___________ (N15)	04 Proprietary Government 05 Federal 06 State 07 Local ☐
IV. SERVICES PROVIDED (Place a '1', '2' or '3' in the blocks See Instructions	01 ☐ Nursing 02 ☐ Physical Therapy 03 ☐ Outpatient Physical Therapy 04 ☐ Occupational Therapy 05 ☐ Speech Pathology 06 ☐ Outpatient Speech Pathology 07 ☐ Social Services 08 ☐ Patient Activities 09 ☐ Pharmacy 10 ☐ Clinical Labs (N16)	11 ☐ Diagnostic X-Ray 12 ☐ Administration and Storage of Blood 13 ☐ Dentistry 14 ☐ Podiatry 15 ☐ Ophthalmology 16 ☐ Psychological Services 17 ☐ Dietary Services 18 ☐ Housekeeping Services 19 ☐ Other ___________
V. NUMBER OF EMPLOYEES (Full-Time Equivalents) See Instructions	1. Registered Nurses ___________ (N17) 2. Licensed Practical/ Vocational Nurses ___________ (N18) 3. Nurses Aides/Orderlies ___________ (N12) 4. All Other Personnel (N27)	

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

I CERTIFY THAT THE ADMINISTRATIVE AND PROCEDURAL REQUIREMENTS CONTAINED IN 42 CFR, SUBPART K (CONDITIONS OF PARTICIPATION FOR SKILLED NURSING FACILITIES) AND/OR 42 CFR SUBPART F (STANDARDS FOR INTERMEDIATE CARE FACILITIES) THAT WERE REVIEWED DURING THE LONG-TERM CARE SURVEY OF __________ HAVE NOT BEEN SUBSTANTIVELY ALTERED, REVISED, OR MODIFIED. I FURTHER CERTIFY THAT I WILL NOTIFY ____________________ ____________________ IF THERE ARE ANY "SUBSTANTIVE CHANGES IN FACILITY MANAGEMENT AND OPERATION" THAT SIGNIFICANTLY AFFECT POLICIES AND PROCEDURES AND THAT NOTICE WILL BE GIVEN IN WRITING BEFORE THE EFFECTIVE DATE OF THE CHANGE.

Signature of Authorized Official	Title	Date

HCFA-1516

INTERVIEWING/OBSERVATION